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ABSTRACT

This literature review describes the volunteer movement and its actual and potential effect on the drug abuse field. The first section outlines the philosophical and historical events and perspectives that have influenced the development of voluntarism. The next section presents data on current trends in the use of volunteers in the largest Standard Metropolitan Statistical Areas as well as descriptions of volunteer characteristics. The third section cites evaluation studies on the use of volunteers. The final section discusses administrative concerns, such as sources of volunteers, their recruitment and training, and recommendations for the design and implementation of successful volunteer programs. An extensive listing of references and an appendix of resources are also included. (KMF)

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National Institute on Drug Abuse

SERVICES RESEARCH REPORT

The Use of Volunteers in Drug Abuse Services: A Review of the Literature

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The Services Research Reports and Monograph Series are issued by the Services Research Branch, Division of Resource Development, National Institute on Drug Abuse. Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy-oriented findings from Branch-sponsored studies. These will include state-of-the-art studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

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Introduction

Considerable effort has been directed toward developing and studying the use of volunteers[1] in the fields of mental health, corrections, education, and health care. Significant volunteer contributions have been cited in regard to institutional care, outpatient counseling, followup or aftercare, and even research and administration. (See the appendix.) It seems reasonable, therefore, that a real potential for intelligent use of volunteers exists in the field of drug abuse treatment and service delivery as well.

Examinations of recent data from the National Drug Abuse Treatment Utilization Survey (NDATUS) indicate that volunteers constitute a substantial proportion of drug abuse treatment staff--18 percent in 1977 and 17 percent in 1978. Furthermore, when the distribution of volunteers by staffing categories is examined, the proportion of volunteers to paid treatment staff is even larger in some staffing categories. For example, 24 percent and 33 percent of those serving as counselors in 1977 and 1978, respectively, were volunteers. In 1977, all attorneys involved in service delivery to drug abuse clients were volunteers. Although this dropped to 69

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[1]For the purposes of this report, "volunteers" are considered to be those persons who perform rehabilitative and treatment services and/or administrative functions and who receive no compensation for these services. Although it can be argued that "token payment," academic grades, course credit, and exchanged goods or services often do not fully repay an individual for services rendered, they are generally considered a form of compensation. Therefore, literature concerning those who receive such benefits in exchange for their work is excluded from this review. Because this report is intended to serve as a resource for drug abuse treatment personnel who are interested in using volunteers, literature pertaining to self-help groups is excluded as well.

percent in 1978, it still indicates that volunteers comprise a clear majority of attorneys involved with drug abuse treatment units.[2]

It is the objective of this literature review to describe the volunteer movement and its actual and potential effect on the drug abuse treatment field. The first section outlines some of the philosophical and historical events and perspectives that have influenced the development of voluntarism. The next section presents data on current trends in use of volunteers in the largest Standard Metropolitan Statistical Areas (SMSAs), across modalities, and nationally by staffing categories. It also describes the characteristics of the volunteer. The third section cites evaluation studies on the use of volunteers. The final section discusses administrative concerns, such as sources of volunteers, their recruitment and training, and recommendations for the design and implementation of successful volunteer programs.

Volunteers have been used most extensively in the areas of mental health, corrections, alcoholism treatment, health care, education, and social service. Relevant literature from these areas has been included in this review so the reader may benefit from this experience.

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[2]These data, as well as justification for the above statements, are presented in chapter 2 under "Current Patterns of Volunteer Utilization in the Drug Abuse Treatment Field."

1. Philosophical and Historical Influences on the Use of Volunteers

The purpose of this section is not to provide a full account of the historical development of voluntarism, but rather to selectively describe the influences of particular social events and ideologies on the development of voluntarism as a social movement. A discussion of the fluctuations in the roles allocated to volunteers over time will be included as well.

SOCIAL EVENTS AND IDEOLOGIES ASSOCIATED WITH THE DEVELOPMENT OF VOLUNTARISM

The proportions of volunteers to professionals who provide treatment and services for clients have fluctuated over time, apparently in response to changes in ideology and technology, to social problems generated by these changes, and to governmental recognition and definition of certain conditions as national concerns. This is evidenced by a brief account of the development of voluntarism in the United States.

Volunteering as a social responsibility has been tied to the Judeo-Christian ethic, with its roots in America traced to the Puritans and their beliefs about voluntary giving (Hardy and Cull 1973). From the beginning of colonization, individuals organized to improve the economic, social, political, and cultural conditions surrounding them (Cain 1976; Hardy and Cull 1973; Leppert 1973a). As the population grew and as the Nation changed from an agricultural to a predominantly industrial society, cooperation among neighboring individuals and families was not sufficient to deal with the complex problems generated by these changes. The increasing complexities of life created a demand for expert knowledge and skills. As a result, professionals were enlisted as the primary treatment and service delivery agents, and the involvement of volunteers in relatively sophisticated aspects of treatment and service delivery (i.e., functions and activities requiring expertise, responsibility, and

accountability) was greatly restricted (Healey 1973; Leppert 1973a; Suarez and Ricketson 1974). Many of the volunteers began to focus their attention on forming charitable organizations to deal with particular problems, generally those of health and social welfare. This is evidenced by the establishment of such organizations as the National Tuberculosis Association in the 1890s, the Society for the Prevention of Blindness in 1905, and the National Society for Crippled Children and the American Birth Control League in 1921. Through such organizations, volunteers sought not only to bring about and influence care and services for specific populations through community education and fundraising projects, but also to promote social and legislative reform to help alleviate the special problems encountered by the groups they attempted to serve (Cain 1976; Hardy and Cull 1973). In the early 1900s, the roles of volunteers in service and treatment delivery were often indirect, if not wholly ancillary.

The Depression drastically altered this situation. Severe economic conditions greatly increased the number of people who needed, but were unable to pay for, medical and social services. In response to this situation, medical professionals encouraged all who could to voluntarily provide health and social welfare services (Cain 1976). Civic and church groups and recreation programs, which assumed caregiving roles in response to the economic crisis, also made extensive use of volunteers (Hardy and Cull 1973).

World War II also increased the number of volunteers. Because many professionals were enlisted to care for military personnel, there were fewer to care for the civilian population. The concurrent influx of women into the labor market increased the demand for social services, despite the decreased availability of professionals. Participation in volunteer activities was again encouraged, this time to fill the gap created by a wartime economic and social system (Hardy and Cull 1973; Healey 1973; Suarez and Ricketson 1974).

By the 1950s, the wartime imbalances of supply and demand in regard to professional treatment and service delivery personnel were largely alleviated. Professionals resumed control of agency and program administration, and reestablished the primacy of academic credentials and expertise as qualifications for those wishing to provide direct care or services to clients. During this period, volunteers served generally as board members, fundraisers, and community liaisons (Healey 1973; Suarez and Ricketson 1974). In addition to these relatively traditional volunteer activities, however, a major development in voluntarism occurred in regard to the welfare of handicapped and mentally retarded children. Parents of these children were instrumental in organizing such groups as the National Association for Retarded Children and the United Cerebral Palsy Association. Unlike traditional volunteer organizations in which the fortunate helped the unfortunate, these organizations were initiated by, and primarily composed of, those more directly concerned or affected by the problem. These volunteer efforts did not concentrate solely either on seeking care from experts or on demanding social and educational reform. Rather, parents were intensely involved in both of these aspects of volunteer work.

Near the end of the 1950s, changes began to occur in the treatment professions that had direct implications for the developments of the 1960s and for current orientations toward treatment and service delivery. Traditionally, the greater demand for services among the disadvantaged segment of the population--those suffering from poor housing, unemployment, racial and ethnic discrimination, poverty, etc.--had been attributed to some physical or mental deficiency. It became increasingly recognized, however, that these conditions extended beyond minority groups such as blacks, Spanish-speaking Americans, and recent immigrants. They were generated in large part by social inequities and prejudice. This new awareness prompted policymakers and program administrators to view drug abuse, emotional disorders, alcoholism, and criminality more as sociological problems (Ryan 1966; Szasz 1960). Simultaneously, professionals, first in the area of mental health and gradually in other areas, discovered that lay workers often seemed as effective in delivering particular services as were their colleagues with postgraduate degrees (Carkhuff 1968; Carkhuff and Truax 1965; Grosser et al. 1969; O'Donnell and George 1977; Poser 1966; Rioch 1966). These two factors encouraged increasing numbers of professionals to reevaluate and reject the traditional clinical treatment model in which only professionals were considered qualified to treat clients. In its place, they began to adopt a public health model of treatment and service delivery. This latter model holds, for example, that mental illness should be prevented as well as treated, and that services should be available equally to the lower, middle, and upper socioeconomic classes (Naylor 1971; O'Donnell and George 1977; Siegel 1973; Visotsky 1967). This shift in professional ideology carried several implications for treatment and service delivery:

- They were removed from the exclusive domain of professionals (Ryan 1966; Sobey 1970);
- They were moved from an isolated, custodial environment into community-based centers (Visotsky 1967);
- The number of persons served was vastly increased, creating a critical manpower shortage (Cowne 1970; O'Donnell and George 1977; Siegel 1973; Sobey 1970); and
- An interest developed in using volunteers in formerly restricted areas (e.g., drug abuse, corrections, mental health, and education) and in roles formerly reserved for the professional alone (e.g., counseling, control and enforcement, and client administration[3]) (Ryan 1966; Sobey 1970).

In the 1960s, the severe manpower shortage was officially recognized by the Federal Government. An influential report by the Joint Commission on Mental Illness and Health (JCMIH) (Albee 1968;

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[3]For a description of specific functions and activities associated with these roles, see the appendix.

Cowne 1969; Sobey 1970) estimated that 3,000 physicians and clinical psychologists per year, in addition to those currently available and in training, would be needed to meet the demand for services. The commission also reported that social workers had extremely heavy caseloads and that mental health agencies were understaffed by 20 percent. This official governmental recognition of a severe manpower shortage in mental health services prompted investigations, new programs, and a drive to recruit volunteers in all areas of health and social service delivery. The establishment of organizations such as National Programs for Voluntary Action and the Center for a Voluntary Society was associated with these initiatives (Blatchford 1974; Schindler-Rainman 1971).

Other Government responses to the findings of the JCMIH included legislation, such as the 1967 amendments to the Social Security Act, which required that all States use unpaid volunteers as an integral part of service programs (Suarez and Ricketson 1974). Federally administered programs such as Volunteers in Service to America (VISTA), the Peace Corps, and the Foster Grandparent Program also were established in response to these findings[4] (Blatchford 1974).

Yet another major result of the work of the JCMIH is related to the ideological shift that occurred in the mental health professions in the late 1950s. Largely through the efforts of this commission, the living conditions of the disadvantaged, as well as the consequences of these conditions, were redefined officially as economic, social, political, and cultural problems (Ryan 1966; Sobey 1970). This served to accelerate the changes initiated within the treatment professions in regard to treatment and service delivery.

Several recent developments influencing voluntarism have been cited in the literature. Because these developments have not been tested by time, it is difficult to assess accurately their effect on the volunteer movement. One of these factors is larger numbers of all types of volunteers now available for work in treatment and service delivery. Segments of the population not heretofore recognized as potential caregivers--youths, college students, professionals, low-income and retired persons, the handicapped, addicts and ex-addicts, prison inmates and ex-convicts, current and former psychiatric patients--are now viewed not only as potential recipients of treatment and services, but also as potential providers of care. This relatively recent recognition, coupled with the population increase, has provided vast and untapped human resources.[5] The

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[4] These programs are not discussed in detail because of the compensations provided to participants.

[5] American Psychiatric Association 1973; Bergman and Doland 1974; Borenstein 1971; Boylin 1973; Coles and Brenner 1968; Cowne 1970; Cull 1974; Eiler 1972; Ewalt 1965; Gay et al. 1972; Hodgman and Stein 1966; Holbrook 1974; Kallan 1973; Leenhouts 1973; Leppert 1973a; Levin 1973; Levine 1968; MacBain 1975; Manasa 1973; Markoff 1969; Mitchell 1966; Morley 1976; Morrison 1967;

degree to which these resources will be used, however, is still to be measured.

A second, often-cited factor influencing volunteer participation is the ideological orientation of the American public. There is some debate within the literature, however, as to exactly what that orientation is. In fact, the views published during the early 1970s and those published during the later 1970s tend to carry diametrically opposed implications for voluntarism. It is too early to tell which of these two ideologies will prove to be more characteristic of the contemporary American population.

The first view is that more and more Americans are adopting a set of values and interrelated attitudes that should lead to increased participation in volunteer activities. This ideological orientation includes:

- A diminishing willingness to allow one's personal identity to be submerged in or ignored by an increasingly mechanistic and bureaucratic society (Schindler-Rainman 1971);
- A searching for personal meaning, identity, self-renewal, and interpersonal relationships (Schindler-Rainman and Lippitt 1971);
- A growing sensitivity toward exploitation, pollution, and misuse of natural and human resources (Schindler-Rainman and Lippitt 1971);
- A devaluation of money as a primary motivation for achievement (Miller 1974; Schindler-Rainman 1971; Schindler-Rainman and Lippitt 1971; Squire 1973);
- A demand for challenge and meaning in work as well as leisure activities (Miller 1974; Schindler-Rainman 1971; Schindler-Rainman and Lippitt 1971; Squire 1973); and
- A growing acceptance of volunteering as an appropriate and worthwhile leisure-time activity (Visotsky 1967), and a concomitant perception of higher status now attributed to volunteer work (Kantor 1967).

Persons who hold such atttitudes might be strongly attracted to the volunteer movement because it would provide opportunities to develop one's talents and individuality, to make concrete contributions toward the welfare of others, and to enjoy the personal satisfaction gained through volunteer work (Schindler-Rainman 1971; Suarez and Ricketson 1974).

Rath 1973; Sainer 1973a,b; Savage 1973; Schindler-Rainman 1971; Silverman 1969; Sulds and Kirschner 1975; Szymanski and Fleming 1971; Termansen 1973; Varenhorst 1974; Widdowson 1971; Wolff 1974.

Other authors, however, believe that there are no longer any commonly accepted values, norms, and attitudes among members of the population, that there is only a growing and pervasive sense of meaninglessness, nihilism, and purposelessness (Albee 1977). Accompanying this orientation is "an unembarrassed denial of human reciprocity and community" (Marin 1975). The individual's world view is centered solely on the self, and individual survival is his/her only concern. There is said to be a general inclination toward hedonism and a total lack of discipline (Albee 1977). This orientation has been termed the "me" generation (Wolfe 1976), the "self-indulgent society" (Albee 1977), and the "new narcissism" (Marin 1975). It is supposedly evidenced by such movements as Erhard Seminar Training (est), ARICA, Scientology, primal therapy, and the resurgence of religious cultism (Albee 1977; Marin 1975; Wolfe 1976). The general acceptance of such a philosophy would be expected, of course, to strongly counteract any motivation toward volunteering and greatly reduce this resource.

A third social factor that is reported to mediate against involvement in volunteer work is the women's liberation movement. The National Organization for Women (NOW) maintains that voluntarism is an exploitation of women (Gold 1971; Squire 1973). Gold's attempt to explain why women volunteer their time and services appears to support NOW's conviction:

> Powerful social disapproval, coupled with their own psychological conditioning of self-negation and ambivalent self-realization, compels women to regard themselves as marginal jobholders except in times of family crisis or poverty. In addition, our free enterprise system is unable to guarantee full employment; women . . . are expendable. As a result, to fill this gap, women have created an impressive network of [voluntary] service systems . . .
>
> (Gold 1971, pp. 534-535)

An elimination of the conditions listed above may not necessarily dissuade women from volunteering, however. As women increasingly gain social approval, develop confidence in their individual abilities, and gain greater access to the occupational and professional job markets (possibly even through volunteer work), a considerable proportion may enter careers. Others, and perhaps a majority, may choose the traditional role of homemaker and/or mother (Gold 1971). Many women now are free to choose a career, to hold a job, to care for a family, to maintain a home, and to volunteer. None of these choices need be mutually exclusive. It is too early to determine the effect of the women's liberation movement on volunteer work. A reduction in volunteering due to increased labor force participation might be expected. On the other hand, increased awareness of social problems, increased educational and occupational qualifications, increased confidence in and utilization of latent or untapped abilities, and increased social acceptance of working outside the home in a variety of capacities may result in more women volunteering their services. The fact that some agencies are using volunteers in psychotherapeutic, medical, and

legal service roles, and in tasks associated with planning administration and public relations (see appendix) would seem to further increase the attraction of volunteer participation for women.

Several additional factors thought to influence voluntarism were mentioned in the literature, but no attempt was made to explain or predict their effect. These factors include employment (MacBain 1975), especially in regard to women; the increasing rate and complexity of social and technological change (Schindler-Rainman and Lippitt 1971; Sobey 1970); and the separation and polarization of social, economic, and political groups (Schindler-Rainman and Lippitt 1971; Sobey 1970).

THE CHANGING ROLE OF THE VOLUNTEER

The role of the volunteer has expanded not only to include a wider range of activities, but also to include activities requiring greater skill, responsibility, and accountability on the part of the volunteer.[6]

With respect to drug education and rehabilitation programs, a publication of the National Center for Voluntary Action Clearinghouse (1975) indicates that volunteers are working in the following areas:

- Diversified services for young people--medical, social, emotional--that deal with the causes as well as the symptoms of drug abuse;
- Residential programs for the treatment of drug/alcohol addiction;
- Walk-in and referral centers for drug abusers, including: telephone counseling, group work, vocational assistance, and crafts;
- Rehabilitation efforts both for drug abusers in prisons and for released offenders with histories of drug abuse;
- Communitywide organizations to coordinate drug abuse prevention efforts;
- Education concerning drug abuse for elementary and junior high school students; and
- Efforts to assist parents whose children are on drugs.

Perhaps the best overall indication of changes in the roles assumed by volunteers in the area of mental health is that provided by Sobey (1970). She reported that as late as 1963, the vast majority

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[6]For a discussion of this trend among hospital volunteers, see Binkley et al. 1968.

(90 percent) of nonprofessionals[7] were performing duties that were considered "menial and routine, involving little which could be called psychotherapeutic." By 1968, however, the majority of nonprofessionals were performing innovative functions--i.e., filling roles and engaging in activities not formerly a part of the services offered by their respective agencies (Ramsey 1972). Sobey found further evidence of this trend in her survey of 185 National Institute of Mental Health (NIMH) projects.[8] She reported that:

- Nonprofessionals were not merely filling gaps created by shortages of professional manpower, but were revealing and responding to formerly unidentified needs of expanding target populations;

- Innovation among nonprofessionals most frequently took the form of providing the recently developed social and educational therapies such as companionship therapy, activity group therapy, tutoring, group counseling, and retraining; and

- Nonprofessionals were used in these innovative roles in 109 (59 percent) of the projects.

A detailed function analysis conducted by Sobey on these NIMH projects indicates that nonprofessionals are primarily used in three general capacities:

- Therapy--individual and group counseling, socializing relationships, milieu therapy--161 projects, 87 percent of which use nonprofessionals;

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[7]Sobey uses the term "nonprofessionals" to include both volunteers and paid paraprofessionals. The data reported are insufficient to separate the two groups in order to present results pertaining to volunteers alone. Despite this difficulty, the study is reviewed here for several reasons. First, Sobey provides the only empirical documentation of the recent changes in roles assumed by volunteers in the area of mental health. Second, it seems especially important to include relevant information from the mental health field because drug abuse therapy is generally offered through these facilities even when a full-scale drug abuse treatment program is not an established component of service delivery. Third, a previous review of the literature (National Institute on Drug Abuse 1979b) indicates that both nonprofessional groups are engaged in essentially similar functions and activities. Therefore, it is believed that, at least in this context, there is no significant qualitative difference between volunteers and paid paraprofessionals, and consequently, that the information presented is not greatly distorted by including paid paraprofessionals with volunteers in the analysis.

[8]Although Sobey conducted an empirical study, her interpretations of the data appear to be extremely positive. Whether this is influenced by the inclusion of both paraprofessionals and volunteers, by statistical results, or by personal bias cannot be determined.

- Special skills--tutoring and retraining; 126 projects, 68 percent of which use nonprofessionals; and

- Community adjustment--finding jobs and homes and facilitating access to community resources--100 projects, 54 percent of which use nonprofesssionals.

Specific activities in which nonprofessionals are engaged, and the respective numbers and percentages of projects reporting nonprofessional involvement in these activities, include:

- Casefinding--63 projects, 34 percent;

- Reception--85 projects, 45 percent;

- Screening--63 projects, 34 percent;

- Caretaking--109 projects, 59 percent; and

- Community improvement--24 projects, 13 percent.

The role of volunteers in the courts and corrections area also has been expanding. An examination of the status of volunteers by the Law Enforcement Assistance Administration (LEAA) (1972) indicates that volunteers are used in such programs as rap sessions, shoplifting diversion programs, tutoring, family-living programs, and pretrial release and probation counseling programs. A 1978 LEAA survey of State and local probation and parole systems (U.S. Bureau of the Census 1978) revealed that more than 20,000 volunteers are currently providing services through these channels.

SUMMARY

Although the existence of voluntarism in America has been traced to the period of colonization, specific historical events and conditions have alternately increased and decreased the supply of and demand for volunteers. This has led to great fluctuations in volunteer utilization. The Depression of the 1930s, World War II, the adoption by professionals of a public health model of treatment and service delivery during the late 1950s, and the official governmental recognition of a severe manpower shortage in the 1960s all contributed to an increased utilization of volunteers. Factors resulting in a decreased utilization of volunteers included professional control over treatment and service delivery policies, and the establishment of postgraduate academic training and clinical expertise as qualifications required for treatment and service delivery functions and activities. More recent influences include the recruitment of volunteers from segments of the population not heretofore recognized as potential caregivers, the ideological orientation of the contemporary American population, the women's liberation movement, and (un)employment, especially that of women. The impact of these influences on the volunteer movement is largely speculative and, as such, prevents confident prediction at this time.

In addition to the fluctuating demand for volunteers, changes in the roles assumed by them have also been reported, largely in response to the major social, economic, and political events described above. At the present time, volunteers are apparently becoming involved in a wider range of activities than previously. Increased involvement is especially evident in activities which require some degree of skill, responsibility, and accountability on the part of the volunteer, and in providing services not formerly offered to clients.

2. The Volunteer as a Contemporary Resource

This section will provide some indication of the current status of volunteer utilization. First, it will present data indicating current patterns of volunteer utilization in the drug abuse treatment field. It will then describe contemporary volunteers, including personality, background, and motivational factors. Finally, it will discuss specific functions and activities currently performed by volunteers.

CURRENT PATTERNS OF VOLUNTEER UTILIZATION IN THE DRUG ABUSE TREATMENT FIELD

The data presented below are derived from the National Drug Abuse Treatment Utilization Survey (NDATUS) conducted annually by the National Institute on Drug Abuse (NIDA). The surveys considered here are those for 1976, 1977, and 1978.

Data from the 1976 NDATUS were examined initially to permit better understanding of the issues associated with voluntarism in drug abuse treatment programs.[9] This examination was limited to five major SMSAs: New York, Washington, D.C.,[10] Chicago, Los Angeles, and San Francisco. It included only methadone maintenance programs, outpatient/daycare drug-free programs, and residential drug-free programs.

Several facts emerged from examining these data. First, as indicated by the data presented in table 1, the incidence of volunteers

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[9]Although it would be desirable to present the most recent statistics, data comparable to those from 1976 were not available for 1977 and 1978. Data for 1976 were obtained from a computer tape supplied to the Institute for Survey Research by the National Institute on Drug Abuse. The 1977 and 1978 data were obtained from NIDA's 1978 NDATUS publication.

[10]The Washington, D.C., programs did not include Narcotics Treatment Administration programs because the data were not included in the 1976 NDATUS.

TABLE 1.—Occurrence of volunteers in treatment programs in five major SMSAs[1]

	Los Angeles	San Francisco	Chicago	Washington, D.C.	New York	Overall
Total number of volunteers	342	144	93	35	20	634
Total number of paid staff	1,051	566	482	363	3,304	5,766
Percent of total staff who are volunteers	24.6	20.3	16.2	8.8	0.6	9.9
Number of programs with at least one volunteer	52	18	9	8	10	97
Total number of programs	74	44	27	29	81	255
Percent of programs with at least one volunteer	70.3	40.9	33	27.6	12.4	38
Mean number of volunteers per program	4.62	3.27	3.44	1.21	0.25	2.46

[1]1976 NDATUS information from programs in New York, Washington, D.C., Chicago, Los Angeles, and San Francisco receiving any Federal funds and being in the methadone maintenance, therapeutic community, and drug-free modalities.

in programs did not correlate with the number of drug treatment programs in the major SMSAs. New York, with 81 programs, had the most programs, but the proportion of staff members to volunteers was 20 to 3,304--or fewer than 1 percent; there was approximately 1 volunteer for every 4 programs. In Los Angeles, which had 74 programs, 25 percent of the staff members were volunteers, and the mean number of volunteers per program was 4.62. San Francisco had 44 programs, 20 percent volunteer staff, and 3.27 volunteers per program; Washington, D.C., had 29 programs, 9 percent volunteer staff, and 1.21 volunteers per program; and Chicago had 27 programs, 16 percent volunteer staff, and 3.44 volunteers per program.

We offer two possible explanations for the differential representation of volunteers in the large SMSAs. First, only programs that received some Federal support were examined. Voluntarism could be more prevalent in private treatment programs, and perhaps these programs are not evenly distributed among SMSAs. Second, the differential might be a reflection of regional attitudes toward drug abuse and drug abusers. In areas where addicts are not seen as threatening, it may be easier to recruit volunteers.

A second interesting fact is that voluntarism did not occur uniformly across treatment modalities. There were few volunteers in methadone maintenance programs in these five SMSAs. Of the 55 programs sampled that provided only methadone maintenance, or methadone maintenance plus methadone detoxification, only 5 (9 percent) had any volunteers. In contrast, 41 percent of the therapeutic communities had volunteers, as did 48 percent of drug-free programs.[11] Here too several hypotheses suggest themselves. For example, it might be that volunteers in drug-free programs perform tasks that are undertaken by paraprofessional counselors in methadone maintenance programs. A recently completed NIDA-sponsored study of counselors showed that there were many more paraprofessionals in methadone maintenance than in drug-free programs (National Institute on Drug Abuse 1979a,b,c).

A third observation is based on the data presented in table 2. Although volunteers are present in all NDATUS staffing categories, when the distribution of volunteers by staffing category is examined, it becomes evident that more than 50 percent of all volunteers were involved in counseling functions.[12] This raises the question of what kind of background these volunteers have, and how they are recruited, screened, and trained.

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[11] These percentages are for those 208 programs in the sample that provided only one modality.

[12] This finding is consistent with the 1977 and the 1978 data as well. In 1977, 53 percent of volunteers were involved in counseling functions, while 56 percent (13 percent degreed and 43 percent nondegreed) were serving as counselors in 1978. (See NIDA 1978, table 4, p. 8, for these data.)

TABLE 2.—Percentage of volunteers in the various categories of the NDATUS staffing matrix[1]

Staffing category	SMSA					
	Los Angeles	San Francisco	Chicago	Washington, D.C.	New York	Overall
Physician	4.4	1.0	7.5	5.7	5.0	4.1
Psychiatrist	3.5	2.1	0	8.6	0	2.9
Psychologist	2.9	3.5	0	20.0	0	3.5
Social worker (MSW)	3.2	3.5	6.4	1.1	5.0	3.3
Nurse	1.8	0	0	2.9	0	1.1
Lawyer	3.5	2.1	0	1.1	0	3.0
Other counselor[2]	48.5	54.2	68.8	1.1	20.0	49.8
Administrative support services	12.3	6.3	12.9	2.9	35.0	11.3
Other	19.9	27.8	4.3	25.7	35.0	20.4
Number of volunteers	342	144	93	35	20	634

[1]1976 NDATUS information from programs in New York, Washington, D.C., Chicago, Los Angeles, and San Francisco receiving any Federal funds and being in the methadone maintenance, therapeutic community, and drug-free modalities.

[2]Only one category appropriate for counseling staff was included in the 1976 survey.

The data presented in table 3 compare the number of paid treatment staff with the number of volunteer treatment staff. As this table shows, volunteers constituted 18 percent of the treatment staff in 1977 and 16.9 percent in 1978. Volunteers are represented in all staffing categories, but the distribution of paid workers to volunteer workers within each staffing category is interesting. For example, approximately 1 of every 10 physicians providing care for drug abuse clients is a volunteer. This rough proportion holds for psychiatrists, psychologists, and social workers as well. Volunteers constitute fully one-third of the nondegreed counselors and the "other"[13] staff providing treatment and other services for clients. Even more striking is the high proportion of volunteer lawyers who counsel clients--100 percent in 1977 and 69 percent in 1978. Slight decreases in the proportions of volunteer social workers (14 percent in 1977 and 10 percent in 1978) and vocational specialists (18 percent in 1977 and 11 percent in 1978) are apparent, along with a moderate increase in the proportion of volunteers assuming roles as counselors (24 percent in 1977 and 45 percent[14] in 1978).

VOLUNTEER CHARACTERISTICS

Background Variables

According to Miller (1974), a U.S. Department of Labor study in the mid-sixties gave a profile of the volunteer as: age--30 to 44; race--white; occupation--housewife; socioeconomic group--middle class. In the early seventies, however, Miller reports a dramatic growth in the number of single, employed people, 20 to 30 years old, of both sexes and all income groups, participating in volunteer activities.

A survey of volunteers' background characteristics as represented throughout the literature shows diversity among volunteers. Successful programs[15] reported that volunteers ranged in age from

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[13] This category is essentially undefined. The fact that one-third of the volunteers currently involved in providing treatment and services to drug abuse clients fall into this category only emphasizes the need for thorough empirical investigation.

[14] This percentage represents the combined proportions of degreed and nondegreed counselors. The statistic was recalculated to provide consistent data.

[15] Despite the extremely positive attitude toward volunteers expressed by virtually all authors, none have defined the characteristics of a "successful" program or provided the criteria underlying their evaluations. "Successful," then, is to be understood as a general, highly subjective descriptor and not one based on standardized observation or measurement.

TABLE 3.—Paid and volunteer staff in drug treatment units by staffing categories
National Drug Abuse Treatment Utilization Survey
April 30, 1977, and April 30, 1978

Staffing categories	1977 NDATUS[1] Actual treatment unit staff						1978 NDATUS[2] Actual treatment unit staff					
	Paid		Volunteer		Total		Paid		Volunteer		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Physicians	1,339	89.0	165	11.0	1,504	100.0	1,401	85.2	244	14.8	1,645	100.0
Psychiatrists	1,141	92.0	99	8.0	1,240	100.0	1,426	90.3	154	9.7	1,580	100.0
Psychologists	1,551	90.6	160	9.4	1,711	100.0	2,111	90.1	232	9.9	2,343	100.0
Social workers (MSW)	1,946	86.2	312	13.8	2,258	100.0	2,083	89.9	233	10.1	2,316	100.0
Nurses	3,569	95.1	183	4.9	3,752	100.0	3,746	94.1	233	5.9	3,979	100.0
Lawyers			148	100.0	148	100.0	96	31.4	210	68.6	306	100.0
Degreed counselors (BA,MA)[3]	11,812	75.5	3,825	24.5	15,637	100.0	7,009	88.0	960	12.0	7,969	100.0
Nondegreed counselors[3]							6,265	67.1	3,074	32.9	9,339	100.0
Vocational specialists	657	81.9	145	18.1	802	100.0	772	88.8	97	11.2	869	100.0
Administrative staff	7,603	95.1	389	4.9	7,992	100.0	7,687	94.8	[4]420	5.2	8,107	100.0
Other	3,534	65.7	1,849	34.3	5,383	100.0	3,042	68.4	[4]1,404	31.6	4,446	100.0
Totals	33,243	82.0	7,275	18.0	40,518	100.0	35,638	83.1	7,261	16.9	42,899	100.0

NOTE--The data presented were recalculated from the Executive Report of the National Institute on Drug Abuse, April 1978, Table 4, p. 8.

[1]Based on 3,107 treatment units.
[2]Based on 3,248 treatment units.
[3]Only one category appropriate for counseling staff was included in the 1977 survey.
[4]These figures are approximations derived from recalculation necessitated by illegibility in the original table.

16 to 93.[16] Although the literature indicates that female volunteers predominated in most agencies and programs,[17] men consistently constituted at least part of the volunteer personnel.[18] Education levels ranged from grade school through graduate school (Beckman 1972; Berger et al. 1975; Cain and Epstein 1967; Feinstein and Cavanaugh 1974; Hague 1969; Horejsi 1972; Hubka et al. 1974; Jarmusz 1969; Keating et al. 1973; Pretzel 1970; Sainer 1971, 1973a; Schoenfeld et al. 1976; Siepker et al. 1977; Silverman 1969). The percentage of unmarried volunteers ranged from 27 percent to 100 percent (Berger et al. 1975; Cain and Epstein 1967; Cole and Cole 1969; Covner 1969; Dye et al. 1973; Evans and Goldberg 1970; Feinstein and Cavanaugh 1974; Horejsi 1972; Keating et al. 1973; Sainer 1973a; Schoenfeld et al. 1976; Tapp et al. 1974). From 20 percent to 80 percent were employed in addition to their volunteer work (Cole and Cole 1969; Covner 1969; Driscoll 1971; Engs and Kirk 1974; Feinstein and Cavanaugh 1974; Hubka et al. 1974; Jarmusz 1969; Sainer 1971; Schwartz 1970).

A few empirical studies provide demographic descriptions of volunteers working in specific treatment and other service areas. The first of these studies, conducted as part of the Volunteers in Rehabilitation Project, was a national survey of volunteers working in rehabilitation facilities.[19] The findings revealed that 90 percent of the volunteers were women, 60 percent were 35 years of age or older, and 40 percent had done at least some college-level work or had earned a bachelor's degree (in comparison to the national

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[16]Beckman 1972; Berger et al. 1975; Cain and Epstein 1967; Cole and Cole 1969; Covner 1969; Engs and Kirk 1974; Evans and Goldberg 1970; Feinstein and Cavanaugh 1974; Gelineau 1967; Gelineau and Evans 1970; Hayler 1975; Heilig et al. 1968; Herman 1976; Hubka et al. 1974; Kallan 1973; Keating et al. 1973; Mackenzie and Bruce 1972; Minor and Thompson 1975; Nicoletti and Flater 1975; Pretzel 1970; Roupe 1973; Sainer and Zander 1971; Sainer 1973a; Schoenfeld et al. 1976; Siepker et al. 1977; Silverman 1969; Tapp et al. 1974.

[17]Beckman 1972; Berger et al. 1975; Covner 1969; Dye et al. 1973; Engs and Kirk 1974; Feinstein and Cavanaugh 1974; Fischer 1971; Gelineau 1970; Hayler 1975; Heilig et al. 1968; Hubka et al. 1974; Jarmusz 1969; Levin 1973; Nicoletti and Flater 1975; Pretzel 1970; Roupe 1973; Sainer and Zander 1971; Sainer 1973a; Schoenfeld et al. 1976; Siepker et al. 1977.

[18]Berger et al. 1975; Cole and Cole 1969; Covner 1969; Cull and Hardy 1974; Engs and Kirk 1974; Evans and Goldberg 1970; Gelineau 1970; Hayler 1975; Horejsi 1972; Jarmusz 1969; Levin 1973; Minor and Thompson 1975; Roupe 1973; Sainer and Zander 1971; Siepker et al. 1977; Tapp et al. 1974.

[19]Although Roupe (1973) does not clearly define the areas of service associated with "rehabilitation," she makes reference to vocational rehabilitation and "the rehabilitation of drug abusers and people alienated from society" (p. 11) within the publication. There is no information on the numbers of subjects in the study, their duties and responsibilities, or the response rate.

figure of 20 percent at this level of educational attainment) (Roupe 1973).

In contrast, Covner (1969) found volunteer alcoholism counselors ($N=56$) to be more evenly divided between the sexes (36 percent male; 64 percent female), and to be comparably educated ($\bar{X}=14$ years of schooling). He also found that most of the men and approximately two-thirds of the women were employed. Approximately 53 percent of the women and 90 percent of the men indicated that they had personal experience with alcoholism.

A third empirical study of volunteers in a specific service area was conducted by Engs and Kirk (1974). Of 74 volunteers working in 5 of the 7 crisis intervention centers throughout the State of Tennessee, 45 percent were men and 55 percent were women. Fifteen percent of the volunteers were considered to be professionals--i.e., physicians, nurses, clergymen, social workers, psychologists, and doctoral students in these disciplines; 85 percent were nonprofessionals. Professionals had volunteered an average of 20.5 months of service, and nonprofessionals had volunteered an average of 19.1 months of service.

Personality Variables

The diversity among current sources of volunteers might lead to the expectation of finding a broad range of both background and personality variables among volunteers. Although the literature indicates that background characteristics do vary widely, authors appear to disagree in regard to personality characteristics. Reports of case studies and program descriptions indicate some consistency among the personalities of volunteers, but empirical studies do not appear to substantiate these more subjective judgments.

Case studies and program descriptions tend to convey a positive impression of the personality characteristics of volunteers. For example, concern about the welfare of others and a desire to help are perhaps the most commonly cited characteristics (Engs and Kirk 1974; Jamison and Johnson 1975; Leppert 1973b; Roupe 1973; Routh 1972; Silk 1972; Silverman 1969; Tyce 1970). Others include empathy (Engs and Kirk 1974; Evans and Goldberg 1970; Jamison and Johnson 1975; Leppert 1973b; Otten and Kahn 1975; Routh 1972; Silverman 1969; Smith 1975; Stoeckel et al. 1975), enthusiasm (Covner 1969; Evans and Goldberg 1970; Leggert 1973b; Otten and Kahn 1975; Pretzel 1970; Routh 1972; Schwartz 1970; Smith and Nelson 1975; Tyce 1970), dedication (Covner 1969; Evans and Goldberg 1970; Howarth 1976; Routh 1972; Sainer 1973a; Stoeckel 1975; Tyce 1970), dependability (Leppert 1973b; Pretzel 1970; Routh 1972; Sainer 1973a), honesty and sincerity (Otten and Kahn 1975; Routh 1972; Schwartz 1970), tolerance and objectivity (Covner 1969; Evans and Goldberg 1970; Leppert 1973b; Routh 1972; Schwartz 1970; Smith and Nelson 1975; Tyce 1970), and flexibility (Covner 1969; Evans and Goldberg 1970; Leppert 1973b; Routh 1972).

Empirical studies, on the other hand, point to differences in personality characteristics among volunteers. For example, a study of college student volunteers working in mental hospitals (N=151) revealed that this group exhibited maturity and control, that they were oriented toward independent achievement, and were sensitive to people and human problems (Kulik et al. 1969). In contrast, a study of 571 male volunteers in a rescue squad and a Big Brothers organization revealed that these men were sociable and extroverted, but that they exhibited a low need for autonomy and independence. They were characterized as actively seeking social approval and the admiration of others (Smith and Nelson 1975). A third study of 374 female volunteers from a variety of service organizations points to yet another personality characteristic. These women were said to feel an obligation to help others regardless of monetary reward (Howarth 1976).

It is impossible to determine whether the differences noted above are due to the measuring instruments employed by various investigators, to age differences among volunteers, to the context in which volunteers worked, or to some other factor. Studies concerned both with the personality characteristics of volunteers and with their effectiveness supply some empirical evidence that there may be significant differences between male and female volunteers.

Despite the extremely positive attitude about volunteers expressed by virtually all authors, however, none have defined the criteria by which they have judged volunteers to be "effective." This term, then, is to be understood as a general, subjective evaluation; it is not based on standardized observation or measurement. Covner (1969), for example, used the California Psychological Inventory to compare the characteristics of the most effective alcoholism counselors with those of the less effective counselors. He reported that the successful female counselors tended to score higher on the criteria "sensitivity to others," "self-control," "spontaneity and social presence in interpersonal dealings," and lower on "dominance" than the less effective female volunteers. He found that the more effective male counselors tended to score higher on "femininity-nurturance," "self-control," and "socialization," to score lower on "good impression," and to score much lower on "sociability" and "dominance" than the less effective male volunteers. Nurturance was the most statistically relevant factor in determining the effectiveness of female volunteers, but the least significant factor for males; effective male volunteers scored significantly higher on the dominance factor than did effective female volunteers; and male effectiveness increased with increases in the achievement factor, but female effectiveness decreased.

Although the findings reported by these investigators may be comparatively inconsistent, they do suggest that different groups of volunteers may exhibit distinctive personality traits. It is also a possibility that different types of treatment and service delivery programs attract volunteers with differing personality characteristics. Although the studies cited have made these inferences, they have not been empirically substantiated.

Motivational Factors

Altruism traditionally has been cited as the sole motive for volunteering. But in recent years there has been a trend among volunteers to emphasize the self-actualizing possibilities of the opportunity to volunteer (Smith 1974). According to Schindler-Rainman and Lippitt (1971), volunteers characterized as "self-actualizers" see opportunities for learning, excitement, and personal growth in volunteering, while those characterized as "servers" see opportunities to make significant contributions. These authors also feel that, while for many volunteers both of these motivational bases are important, there is probably a different priority for different types of persons and in different program settings.

This conclusion appears to parallel the developing ideologies associated with the "me" decade or the "new narcissism" of the 1970s discussed earlier. As increasing proportions of the population lose the social perception of community--i.e., lose the sense of collective responsibility for the fate of others around them--they tend to turn inward and increasingly become motivated by individual survival and, therefore, self-interest (Albee 1977; Marin 1975; Wolfe 1976). As more volunteers begin to adopt this ideology, then, one would expect an increase in self-actualizing motivations and a concomitant reduction in altruistic motivations.

The findings of several empirical studies appear to justify this expectation. For example, Hayler (1975) reported that the volunteers serving at the Concord Mental Health Center were motivated not only by the desire to help, but also in order to learn, to test a future career, and to reenter the mental health field. Engs and Kirk (1974) report that 72 percent of the 74 volunteers working at crisis intervention centers throughout the State of Tennessee said that they volunteered to help others. The remaining 28 percent, however, were motivated by a desire for self-growth, experience, or course credit.[20,21]

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[20]These investigators also found significant differences in length of service when the motivations of volunteers were considered. They reported that the average length of service for those who had volunteered to help others was 22.1 months in contrast to an average of 13.1 months for those who had volunteered for self-growth, experience, or course credit. A confident interpretation of these findings and their implications for treatment and service delivery is difficult. It might be that the self-actualizing volunteers completely abandoned their attempts to help others when their own goals were realized (for example, completion of a particular course). It might also be that they assumed paying jobs in the field after gaining sufficient experience or the required academic credentials and continued to provide treatment and services for clients. No data were found to support or contradict either outcome.

[21]The definition of volunteers employed in this review excludes individuals who receive compensation (e.g., course credit)

More detailed empirical investigations of volunteers' motivations indicate essentially similar findings. A study of 50 suicide and crisis intervention service volunteers (McGee et al. 1972), for example, revealed that most volunteers wanted to help or to gain satisfaction from helping others (73 percent). Considerable proportions of the sample volunteered to gain self-knowledge or further self-development (45 percent), to gain an understanding of suicidal behaviors and crisis intervention (39 percent), to gain valuable practical experience (37 percent), and because of a desire for greater emotional involvement with others (37 percent). In contrast, only 20 percent of the volunteers stated that they were motivated by the perception of crisis intervention as furthering the achievement of broad social goals.

Perhaps the most striking example of both this motivational shift and the variation in motives between groups of volunteers was reported by Evans and Goldberg (1970). In their study of volunteers to the case aide volunteer training and demonstration model at Boston State Hospital, the investigators compared the questionnaire responses of a group of volunteer Maryknoll seminarians (a group expected to be quite altruistic) to those of Harvard students who had volunteered at an earlier time. The results of this comparison indicated that even the seminarians' prime underlying motive was a desire to deepen and broaden their self-awareness. The Harvard students also had self-actualizing motives, but these appeared to be more achievement oriented than those of the seminarians. Their motives for volunteering included the opportunity to enhance their own theoretical knowledge through fieldwork, the opportunity to test the possibility of a mental health career, and the opportunity to escape the university classroom environment for the "real world."

Another example that appears to substantiate the shift away from altruistic motives toward those of self-help or self-actualization is provided by Suarez and Ricketson (1974). These authors indicated that only a few of the volunteers offering direct service in a protective service agency were motivated by a desire to do something about the problems of child neglect and abuse. Most were homemakers who wanted a change from familial duties. Still others offered their services as a means of filling lives left incomplete by business careers or counteracting loneliness and isolation (also Aves 1969). Although such motives might call into question the dedication and concern with which these volunteers approach their

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for services rendered. The definition employed by Engs and Kirk (1974), however, was less restricted and included all individuals who were not part of the paid program staff. Furthermore, these authors do not provide sufficient information to allow the exclusion of volunteers receiving such compensation. Since so few empirical studies of volunteer motivations have been conducted, the Engs and Kirk study is included despite the problems noted.

work, Suarez and Ricketson contend that the self-oriented or self-actualizing volunteer was the most reliable and the most loyal to the agency.

Discussions of volunteers' motives in case study reports and program descriptions largely confirm the findings of empirical studies. Furthermore, this literature appears to indicate that program administrators and directors are aware of this new motivational trend among volunteers. Various authors stated that volunteers were motivated by a desire to actively confront current issues and to make valuable contributions to solving them (Dwarshuis et al. 1973; Fischer 1971; Keating et al. 1973; McGee et al. 1972; Michener and Walzer 1970; Pretzel 1970; Rich 1973); by a desire to experiment with different tasks and work roles or to explore a potential career (Dwarshuis et al. 1973; Howarth 1976; Michener and Walzer 1970; McGee et al. 1972; Pretzel 1970); by a desire to establish their independence (Howarth 1976; Keating et al. 1973; Smith and Nelson 1975); and/or by a need for enhanced self-esteem and recognition (Dwarshuis et al. 1973; Faulkner 1975; Howarth 1976; Smith and Nelson 1975).

FUNCTIONS AND ACTIVITIES OF THE VOLUNTEER WORKER

The functions and activities in which volunteers were reported to engage have been classified into 12 categories: community education, interagency relationships, program administration, counseling in the community, control and enforcement, client administration, personal aid to clients, socializing with clients, psychological/psychiatric services, medical/dental services, legal services, and research. Literature that discussed volunteer work in each of these classifications was then listed according to appropriate treatment or service delivery area.[22] The following brief description will attempt to provide some indication of the general level of volunteer participation in particular functions and activities, as well as the different levels of volunteer involvement among treatment and service delivery areas.

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[22]Several resource materials referred to volunteers "in general" and did not permit classification by the four treatment/service delivery areas of primary concern. Other materials referred to volunteer assignments within programs or agencies related to education, social service, health, etc., which became too numerous to include as individual categories. Consequently, general references to volunteer participation and those that reported work in areas other than drug abuse, alcoholism, mental health, and corrections have been included under the "other" category. This strategy allows the retention of valuable information without complicating its presentation to the point of diminishing the reader's understanding or distracting him/her from the primary concerns of the report.

A review of the literature reveals that many volunteers work in community education, especially in the fields of mental health and social services. Volunteers in this field were reported to disseminate information concerning particular programs or the general treatment and service delivery area, to provide information to individuals who contact the agency with questions or problems, to participate in community workshops, etc.

The recent trend toward coordinating treatment and service delivery among agencies, in contrast to the formerly independent and fragmented approach, appears to be evident in the frequent use of volunteers to develop and coordinate interagency relationships. For example, volunteers have been reported to develop, promote, and coordinate agency and/or community programs, services, and resources; to organize community groups in prevention efforts; and to act as interagency liaisons.

Many volunteers also are involved in several aspects of program administration. Although many authors stated that volunteers performed relatively routine clerical and secretarial tasks, they also reported that much of the volunteers' work involved more skillful and responsible activities, such as assisting clients in completing forms related to their admission, progress, and discharge; writing reports describing therapeutic[23] interactions between the client and the volunteer; and putting clients and community members in contact with an appropriate treatment program or service delivery agency.

Volunteers were found to be especially active in soliciting or providing equipment and services for clients and in fundraising activities. Some of the reports referred to such services as making pillows for patient lounges or providing toys for children's hospital wards. On the other hand, many referred to procuring buildings to house new or expanded programs, completely renovating day rooms and wards for psychiatric patients, conducting successful campaigns for revising and improving program and treatment policies, and establishing and maintaining new or additional programs for formerly untreated or unserved segments of the population.

Volunteers in each of the five treatment and service delivery areas were also reported to provide training for counselors and for other volunteers. These individuals were often either experienced volunteers or professionals who worked in the general treatment area or taught courses related to it.

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[23] The term "therapeutic" sometimes refers to a friendship relationship that is intended to provide emotional support to clients; at other times it refers to in-depth psychotherapy. The former definition is used most often when the particular volunteers are nonprofessionals, while the latter generally applies when physicians, psychiatrists, psychologists, etc., volunteer their services. "Therapeutic," then, should be understood in this broad context.

Intense volunteer involvement also is reported in relation to counseling in the community, especially in regard to outreach, and observing and assessing community problems and client needs. It is a common belief that volunteers are unrestricted by official titles, "professionalism," and unfamiliar values and lifestyles, and consequently can move freely within communities. Because of their background experiences, indigenous volunteers are reported to be especially suited to counseling work in the community, as well as to serving as an information resource for agency planning and treatment staffs. In addition, indigenous volunteers may be used to locate clients who have broken contact with the agency.

Slightly fewer volunteers participate in crisis intervention than in counseling in the community. In the area of drug abuse treatment, volunteers were used to "talk down" clients, to respond to emergency calls, and to provide aid and support to clients in trouble in the clients' homes, in treatment agencies, in hospital emergency rooms, etc.

Many volunteers were reported to be working in client administration, especially in mental health, education, and social service areas. Volunteers were reported to be relatively autonomous in referring clients to appropriate agencies and in their capacity as liaison between program staff and clients and/or the community. Only in the areas of drug abuse treatment and mental health, however, were volunteers reported to evaluate or diagnose clients' problems independent of professional staff. This finding might be anticipated, however, especially in the case of ex-addict volunteers or those who have gained considerable experience with the drug-abusing population, and in the case of psychiatrists and psychologists.

Another category of extensive volunteer participation is that of personal aid to clients--interpreting the program or services available to clients; assisting clients in securing employment, financial assistance, housing, and medical and dental care; providing social and emotional support to clients; and advising and tutoring clients.

One area of greatest volunteer involvement reported by the literature was socializing with clients--conducting recreational programs or group activities; escorting clients on trips; serving as companion, friend, or sponsor; and providing entertainment. Although this category of tasks may seem to be an insignificant assignment, it is reported to be of considerable therapeutic value, especially in the areas of mental health, corrections, and social service. In fact, both paid staff and clients appeared to agree that there was something inherently therapeutic about the volunteer's "just being there."

Use of volunteers to provide psychological or psychiatric services appears to be quite low. This is not surprising considering the extensive academic training and the high level of expertise generally required to render effective treatment. Group counseling conducted by volunteers tends to focus on problems related to treatment or problems associated with daily living rather than on in-depth

self-exploration therapy. Exceptions to this occur when the volunteer counselor or group leader is a professional.

Telephone crisis intervention, which is often performed by volunteers, is not considered providing psychological or psychiatric services because it is the opportunity to interact with someone who will listen and empathize that is important--not the clinical expertise of the hotline volunteer. Also, these services are often a means of referral rather than treatment.

Volunteers are engaged in conducting investigations and surveillance only in the corrections field. Most of the reports of volunteer participation in these activities referred to professionals--such as psychiatrists, attorneys, and advanced graduate students in criminology--who conducted pre-sentence investigations and cooperated in making recommendations to the court in regard to the disposition of clients.

The literature also reported little use of volunteers to provide medical and dental services and legal services, or to conduct research.

SUMMARY

Relatively recent data on patterns of volunteer utilization in drug abuse treatment programs indicate: (1) that volunteers constitute approximately 20 percent of program staff; (2) that voluntarism does not occur uniformly across modalities; and (3) that volunteers are represented in all NDATUS staffing categories, but are most heavily involved in counseling functions.

Surveys of the background characteristics of volunteers have shown that there is no typical volunteer. He or she may be almost any age, be of either sex, be married or single, be employed or unemployed, have little formal schooling or be highly educated.

Although virtually all authors reported a wide diversity of demographic characteristics among volunteers, this unanimity was not found in regard to personality characteristics. Empirical investigators reported a diversity among the personality characteristics of volunteers--a diversity that varied by sex, the particular group being studied, the treatment and service delivery area, and the specific instrument employed. The reports of case studies and program descriptions, however, cited several "universal" characteristics of the "volunteer personality." These characteristics included a concern for the welfare of others, a desire to help, empathy, enthusiasm, dedication, dependability, honesty, sincerity, tolerance, objectivity, and flexibility.

Most authors cited considerable diversity in motives for volunteering. Although some volunteers were reported to have the traditional altruistic motives, there was an increasing trend toward self-actualization or self-interest as a consideration in the decision to volunteer, as indicated by both the empirical investigations and

the case studies and program descriptions. The most frequently cited motives included a desire to confront current issues and to make valuable contributions to solving them; a desire to experiment, to gain experience with different tasks and work roles, or to explore a potential career; a desire to establish one's independence; and a desire for enhanced self-esteem or recognition.

The increasingly wide diversity among characteristics and abilities of volunteers, coupled with the recent trend toward achieving self-actualization through volunteer work, has caused the role of the volunteer to be redefined. This redefinition includes a wider range of tasks, functions, and activities that require greater skill, responsibility, and accountability on the part of the volunteer. This can be seen in an inventory of functions and activities in which volunteers are reported to engage: community education, inter-agency relationships, program administration, counseling in the community, control and enforcement, client administration, personal aid to clients, socializing with clients, psychological and psychiatric services, medical and dental services, legal services, and research.

3. Outcome Variables

Attempts to evaluate the effect of use of volunteers have originated from several different perspectives. Some authors and investigators have been concerned with the volunteer's ability to satisfactorily perform specific tasks or to achieve some observable positive change in clients or patients. Other evaluators have been more concerned with the effects of volunteering on the volunteers themselves, with client satisfaction, or with staff reactions to a volunteer program. Consequently, each of these four indices will be considered.

VOLUNTEER EFFECTIVENESS

The literature is replete with qualitative evaluations--descriptions of demonstration projects and programs and descriptions of the experiences of individuals who work in treatment and service delivery programs--that attest to the satisfactory or outstanding performances of volunteers or to the gains made by patients or clients assigned to volunteers. This appears to be the case in all areas of treatment/service delivery under consideration: drug abuse treatment;[24] alcoholism treatment;[25] mental health treatment;[26]

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[24]American Hospital Association 1973; Borenstein 1971; Boudin et al. 1977; Davis 1970; Dwarshuis et al. 1973; Gay et al. 1972; Hague 1969; Mackenzie and Bruce 1972; Markoff 1969; Termansen 1973.

[25]Driscoll 1971; Madden and Kenyon 1975; Manohar 1973.

[26]American Psychiatric Association 1973, 1977; Beier et al. 1971; Blatt 1969; Burnis and Ackerly 1969; Burrill 1966, 1969; Chaplan et al. 1966; Clark 1966a,b; Cohen 1966; Cole and Cole 1969; Collins 1967; Cooper 1967; Cooper and Southard 1966; Corning 1967; Cowne 1969, 1970; Eiler 1972; Eisenstein 1969; Epstein 1967; Evans and Goldberg 1970; Featherman and Welling 1971; Gelineau 1967; Gelineau and Evans 1970; Glassmann and Turner 1967; Green 1971; Greene and Mullen 1973; Greenbank and Cameron 1968; Grob 1967; Hague 1969; Heilig et al. 1968; Hetherington and Rappeport 1967; Hladky 1969; Hodgman and Stein 1966; Holand and Voss 1968; House 1968; Janzen 1974; Kotzen 1966; Kraft 1966; Kraus 1967; Lachenmeyer 1971; Lear 1972; Levine 1968; Malhotra and Olgiati 1977; Mendelsohn and Gold 1968;

correctional treatment and services;[27] and social, educational, and medical services.[28] Despite the extremely positive evaluations of volunteers made by virtually all authors, none have defined the criteria by which they have judged volunteers to be "effective." This term, then, is to be understood as a general, highly subjective evaluation and not one based on standardized observation or measurement.

Relatively few quantitative or empirical studies of the effectiveness of volunteers were found, however, and even the findings of these few studies must be interpreted with caution due to inherent methodological problems. Some of the major problems limiting the validity and generalizability of these results are:

- What little research has been conducted generally involved a single agency or program and usually did not employ a control group.
- Where established criteria were used to measure volunteer characteristics or effective utilization, these criteria often consisted of standardized psychological inventories or criteria selected by the primary investigators and were assumed to be indicative of outcome measures, rather than tested empirically.
- Virtually no attempts to relate volunteer characteristics or effectiveness to the effect on treatment and services--such as observed changes in client behavior and treatment and service outcome attributed to volunteer-client interaction--were found.

Michener and Walzer 1970; Minor and Thompson 1975; Mitchell 1966b; Nicoletti and Flater 1975; Nicoletti and Flater-Benz 1974; Patterson and Patterson 1967; Pederson and Babigian 1972; Pretzel 1970; Rath and David 1973; Reding and Goldsmith 1967; Remar 1967; Rieger et al. 1969; Roth 1967; Sainer 1972; Sata 1972; Savage 1972; Schulman 1968; Schwartz 1970; Shore et al. 1972; Smiley 1973; Snyder 1975; Spoerl 1968; Stein 1967; Thisse 1967; Tyce 1970; Warren 1968; Widdowson and Griffiths 1971; Wiseman 1969; Witkin 1973; Wolff 1974.

[27]Abrams 1970; Case 1973; Eiler 1972; Ellenbogen and DiGregario 1975; Fox 1973; Goodard and Jacobson 1967; Horejsi 1973; Ingram and Swartsfager 1973; Stoeckel 1975; Szymanski and Fleming 1971; U.S. Department of Health, Education, and Welfare 1971.

[28]Amenta 1974; Aud 1973; Boylin 1973; Cain 1976; Cain and Epstein 1967; Coles and Brenner 1968; Cowne 1970; Ferry 1968; Frank et al. 1969; Freidin et al. 1970; Friedman 1975; Harkness and Dougherty 1968; Herman 1976; Hilferty and Scott 1974; Holbrook 1974; Hughes et al. 1972; Kleiman et al. 1977; Kohn 1973; MacBain 1975; McCavern 1967; Morley 1976; Muro 1974; Nolan 1977; Pearse 1966; Rubenstein and Rubenstein 1972; Schmitt 1975; Siegel 1973; Silverman 1969; Squire 1973; Suarez and Ricketson 1974; Sulds and Kirschner 1975; Varenhorst 1974; Yawkey and Silver 1975.

- No longitudinal studies were found that might indicate significant relationships between use of volunteers or particular volunteer characteristics and long-term client benefit.

- No studies were found that indicated differences in overall functioning or effect on treatment and services between agencies, or programs within agencies, that use volunteers and those that do not.

Because of the methodological problems inherent in most of the investigations conducted and because the findings were sometimes in conflict, the following studies[29] should be considered indicative of volunteer effectiveness, but not accepted as decisive.

In the correctional setting, Ku et al. (1975) compared outcome measures of three groups of probationers: high-risk individuals assigned to volunteer probation counselors (N=40), high-risk individuals participating in routine probation programing (N=44), and low-risk individuals participating in routine probation programing (N=20). The investigators reported that although high-risk probationers who had been assigned to volunteer counselors did not perform as well during the probation period as did the low-risk group, their performance was often significantly better than that of the high-risk control group. For example, probationers assigned to volunteer counselors committed 46 percent fewer offenses and showed significant reductions in the more serious criminal offenses (theft-related and antisocial offenses). Although no significant differences were found between the two high-risk groups at the beginning of probation, the probationers with volunteer counselors also scored significantly higher on the Responsibility, Socialization, and Achievement via Conformance scales of the California Psychological Inventory administered at the end of the probationary period. Ku et al. concluded that volunteer counseling relationships were effective in approximately 75 percent of the cases.

Information published by the Law Enforcement Assistance Administration (1972) indicates that volunteers have been effective in pretrial and probation programs. In the San Francisco Jail Project, VISTA volunteers assisted city judges in establishing a program of pretrial release for misdemeanants. More than 15,000 defendants, persons who could not have made bond and who would have been retained in jail, were released on their own recognizance as a result of this program. The success of the volunteer effort was evaluated in terms of the $350,000 savings in custodial costs, the ability to delay plans for building a new detention facility, and the fact that fewer than 4 percent of those released failed to appear in court. In a Denver County probation program, volunteers were assigned to counsel 13 probationers, while 13 others were main-

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[29]The studies presented were conducted only in the areas of mental health and correctional treatment and services. No empirical studies that evaluated the effectiveness of volunteers working in drug abuse, alcoholism, or other areas of interest were found.

tained in the traditional process. In an analysis of sociometric self-evaluations administered before the probationary period and 1 year later, it was found that probationers assisted by volunteers had improved on 12 of the 13 scales, while probationers in the traditional program improved on only 3 scales and actually regressed on 10.

There is also evidence to indicate that volunteer programs are not always successful. Berman (1975), in evaluating a probation program using lawyer volunteers in counselor roles, reports no positive effects in terms of arrest rates, employment rates, or job satisfaction. In attempting to explain these findings, he cited several factors that might have had a detrimental effect on the experiment. First, the program began when the average man involved had been out of prison for an average of 6 months. The most critical period for ex-offenders, however, is thought to be the first month after release. Second, having a high-status friend might not be as important to ex-offenders as had been expected. Third, the negative findings might have been the result of the short duration of the study; the effects of having such a friend might require longer than 9 months to emerge.

Berman also offered suggestions for improving this type of program. He believes:

- It should be used with parolees who are just being released or, ideally, the volunteer-parolee relationship should be established before the man leaves prison;

- Volunteers should be screened to maximize the selection of attorneys who can relate to parolees and who have a high tolerance for frustration; and

- The availability and value of community assistance agencies should be emphasized in the training of volunteers.

Berger et al. (1975) likewise found no reduction in delinquent behavior among juvenile probationers assigned to volunteer probation officers, tutors, and group discussion leaders. The investigators believed that this was because the program was coercive; it was administered by the court and was compulsory. They also found that all volunteers either did not contact or did not maintain contact with the probationers assigned to them. To counteract this problem in future programs, Berger et al. suggested that some system of monitoring the frequency of probationer-volunteer interaction be devised, and further recommended that probationers and volunteers spend a minimum of 3 hours a week together, rather than the 1 hour required in this program. They also suggested that particular characteristics of the volunteers were important and might be considered in recruiting, selecting, and training future volunteers. These characteristics include:

- A relatively cynical attitude toward society and a less rigidly conventional attitude toward the law;

- A perception of other adolescents as being more delinquent than the probationers with whom they work; and

- Some element of authority in the volunteers' orientation toward the probationer; the volunteer should act as a big brother or sister instead of acting like a friend.

Perhaps the most striking evidence indicating that volunteer programs are sometimes unsuccessful is provided by Cook and Scioli (1975). These investigators substantively and methodologically evaluated research studies (N=45) that had attempted to measure the effectiveness of volunteer programs in courts and corrections; the specific volunteer duties and responsibilities for each study were not described. They concluded that:

> . . . there is no clear-cut evidence that volunteer programs in courts and corrections are more successful than other program alternatives in achieving common objectives. The body of technically sound evaluative research on this question is, simply put, too thin.
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> p. 91

Several empirical studies documenting the effectiveness of volunteers working in mental health programs and agencies were also found.[30] For example, Truax (1966) found volunteers to be at least as effective as professional therapists in communicating empathy, warmth, and genuineness to hospitalized patients. Beck et al., in two studies (1963, 1965), reported significant increases in discharge rates and in measured social behavior for chronic psychotic patients receiving the services of college volunteers (also Bergman and Doland 1974). Similar results also were reported by Verinis (1970) and Katkin et al. (1975). Verinis found that chronic mental patients exhibited better ward behavior and a better sense of humor, were more cooperative and less withdrawn and verbally hostile, and had a better potential for discharge when assigned to a volunteer therapist. Katkin et al. reported that hospital readmission rates were significantly reduced for women participating in an aftercare program staffed by volunteer therapists. Volunteers have also been positively evaluated in roles as youth leaders (Feinstein and Cavanaugh 1974), as child behavior therapists (Wahler and Erickson 1969), as companionship therapists (Arthur et al. 1973), as telephone counselors (O'Donnell and George 1977), and as suicide prevention supervisors (Martz 1974).

EFFECTS OF VOLUNTEERS

Although the purpose of voluntarism is usually to provide treatment or services to the patient or client population, many authors agree

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[30]For publications that provide a review of mental health programs utilizing volunteers, see Cowne (1969, 1970), McGee et al. (1972), and Siegel (1973).

that volunteers benefit, both socially and psychologically, from rendering service to others. The most commonly cited social benefits derived from volunteer experience include: the opportunity to make friends and take part in meaningful activities (Beverley 1975a,b; Einstein 1973; Friedman 1975; Naylor 1971; Sainer 1973a); the opportunity to become familiar with treatment agencies and program personnel (Brown and Ishiyama 1968; Cole and Cole 1969; Haddock and Dundon 1951; McCann 1964; Spoerl 1968; Wanderer and Sternlicht 1964; Wolff 1974); the opportunity to learn (Beverley 1975b; Brown and Ishiyama 1968; Brunell 1967; Burnis and Ackerly 1969; Delworth et al. 1974; Gelineau 1967; Haddock and Dundon 1951; Levine 1968; McCann 1964; Naylor 1971; Rapp 1974; Roupe 1973; Wanderer and Sternlicht 1964; Witkin 1973; Wolff 1974); and the opportunity to explore a potential career choice or to gain access to a paid position (Brown and Ishiyama 1968; Burnis and Ackerly 1969; Cytryn and Vihlein 1965; Delworth et al. 1974; Dowds et al. 1969; Ewalt 1967; Haddock and Dundon 1951; Klugman and Klugman 1964; Levine 1968; Siepker et al. 1977; Spoerl 1968; Umbarger et al. 1962; Witkin 1973). Psychological benefits gained through the volunteer experience are reported to include: a feeling of satisfaction in helping others (Bergman and Doland 1974; Beverley 1975b; Brown and Ishiyama 1968; Burnis and Ackerly 1969; Cole and Cole 1969; Green 1971; Kallan 1973; Kleiman et al. 1977; Lavker and Rosett 1966; Morley 1976; Sainer 1973a; Umbarger et al. 1962; Widdowson and Griffiths 1971); a positive shift in attitudes toward those being helped and a deeper understanding of patients' or clients' problems (Beckman 1972; Bergman and Doland 1974; Beverley 1975b; Brown and Ishiyama 1968; Brunell 1967; Burnis and Ackerly 1969; Clark 1966b; Ewalt 1967; Gelineau 1967; Green 1971; Holzberg 1963; Holzberg and Gewirtz 1963; Holzberg et al. 1966, 1964b; Klugman and Klugman 1964; Kulik et al. 1969; Pretzel 1970; Rapp 1974; Witkin 1973); an increased sensitivity to others' feelings (Beier et al. 1971; Brown and Ishiyama 1968; Burnis and Ackerley 1969; Doud and Regan 1965; Ewalt 1967; Green 1971; Holzberg et al. 1964a, 1966; Knapp and Holzberg 1964; Pretzel 1970; Rioch et al. 1963; Roupe 1973; Spoerl 1968; Witkin 1973); the opportunity for self-actualization or personal fulfillment (Brown and Ishiyama 1968; Cole and Cole 1969; Delworth et al. 1974; Doud and Regan 1965; Gold 1971; Holzberg et al. 1964a, 1966; Knapp and Holzberg 1964; Lavker and Rosett 1966; Rioch et al. 1963; Roupe 1973; Widdowson and Griffiths 1971; Witkin 1973; Wolff 1974); an increased ability to cope with personal problems (Beier et al. 1971; Ewalt 1967; Kallan 1973; Kleiman et al. 1977; Levine 1968; Morley 1976; Pretzel 1970; Rapp 1974); and enhanced self-esteem (Bergman and Doland 1974; Brown and Ishiyama 1968; Delworth et al. 1974; Doud and Regan 1965; Gold 1971; Holzberg et al. 1964a, 1966; Kallan 1973; Knapp and Holzberg 1964; Naylor 1971; Pretzel 1970; Rioch et al. 1963; Sainer 1973; Savage 1972; Witkin 1973).

A few empirical studies also revealed that volunteers themselves derived benefits from their experience in treatment and service delivery programs. For example, Kulik et al. (1969) found that as a result of volunteer experience in a mental hospital, college students came to view psychiatric patients as more organized and reality oriented, less confused and dreamy, more capable of

friendship and warmth, more passive and predictable, and less threatening (also Chinsky and Rappaport 1970). These investigators also reported that the students became increasingly disillusioned about the hospital itself, eventually perceiving it as a custodial rather than a curative institution. King et al. (1970) reported a greater change toward self-acceptance among college students who were volunteers in a psychiatric hospital than among nonvolunteer students (also, Doud and Regan 1965; Dowds et al. 1969; Holzberg et al. 1964a, 1966; Knapp and Holzberg 1964; LeVine 1966; Rioch et al. 1963).

There is also some evidence to suggest that volunteering influences later work roles. Dowds et al. (1969) reported that more volunteers who worked in mental hospitals or at a summer camp for mental patients, as compared to a control group, intended to spend subsequent summers engaged in mental health volunteer activities. Furthermore, the number of volunteers who planned careers in the mental health profession increased significantly after the summer's experience.

CLIENT SATISFACTION

Few investigators have been concerned with client satisfaction in regard to volunteer treatment and services. What scant information is available, however, indicates that clients perceive a particular credibility in the volunteer (Rioch 1966). The fact that the volunteer is not paid, but persists in showing a warm, sympathetic interest in clients and patients appears to make an impression on those served (Roupe 1973; Verinis 1970).

One empirical study also provides an indication of the satisfaction clients derive from interactions with volunteers. Stoeckel et al. (1975) surveyed 50 juvenile offenders who had been interviewed by volunteers during intake and for purposes of preparing predisposition reports. They reported that 93 percent of the juveniles believed the volunteers had done "a good job" and that 83 percent said they would want to be interviewed by the same volunteer if another court hearing were necessary.

STAFF REACTIONS

Descriptions of demonstration projects, programs, and reports of the experiences of persons involved in treatment and service delivery often indicate that staff exhibit adverse reactions to the introduction of volunteer programs. Staff are said to be skeptical of the nonprofessionals' ability to provide treatment and services that require a high level of expertise (Kantor 1967; Naylor 1971; Stoeckel 1975; Suarez and Ricketson 1974) and some fear that their jobs or status are in jeopardy (Kantor 1967; Krebs 1971; Malhotra and Olgiati 1977; Naylor 1971; Routh 1972). Some are said to fear that patients will experience setbacks due to volunteers' therapeutic

errors (Malhotra and Olgiati 1977), or that volunteers will not respect the clients' confidentiality.

Once staff have either an opportunity to participate in volunteer training and supervision or to observe the volunteers' interaction with patients, they are generally reassured and adopt positive attitudes toward using volunteers (Burnis and Ackerly 1969; Stoeckel et al. 1975). A clear delineation between staff and volunteer roles is also said to encourage the staff's acceptance of volunteers.

More positive reports indicate that staff begin to view volunteers as valuable additions to the treatment/service delivery team (Burnis and Ackerly 1969). Volunteers are also said to introduce a fresh perspective into the agency or program and to stimulate staff in seeking alternative methods of relating to clients and patients (Brown and Ishiyama 1968; Green 1971; Holzberg and Knapp 1965; Wanderer and Sternlicht 1964).

SUMMARY

There are many qualitative evaluations that attest to the effectiveness of volunteers, but there is also evidence to suggest that qualitative and quantitative evaluations do not always yield similar results. Although few empirical evaluations were found, most indicated that volunteers were successful.

The literature reports that volunteers benefit from the volunteer experience as well as the clients and patients who are the recipients of service. Volunteers enjoy the opportunity to participate in meaningful activities, to explore potential work roles, and to develop their talents and abilities. The literature also indicates that volunteers develop an increased sensitivity toward others, an increased ability to cope with personal problems, and enhanced self-esteem.

The few investigations that have been made of client satisfaction with the treatment and services they receive from volunteers indicate that clients generally are satisfied. Although staff are initially skeptical, staff reactions also are generally positive once they have observed volunteers interacting with patients or clients.

4. Administration of Volunteer Services

This section outlines commonly expressed rationales for and against using volunteers. It also describes procedures for recruiting, selecting, and training volunteers and provides recommendations for designing and implementing successful volunteer programs.

GENERAL CONSIDERATIONS IN THE DECISION TO INITIATE A VOLUNTEER PROGRAM

Rationales for Using Volunteers

Rationales for using volunteers generally fall into two categories--cost efficiency and quality of service.

Cost efficiency. The preparation and training of professionals for social service delivery has not been able to keep pace with the growth of traditional programs. In recent years, there has also been an increasing recognition that traditional services do not fully meet client needs, and that new and expanding programs and services must be developed if we are to deal effectively with the economic, social, political, and cultural problems confronting our society.

The paraprofessional movement--training and using persons without advanced academic credentials to perform functions not requiring a high level of clinical expertise--is one strategy for alleviating these problems. The use of paraprofessionals not only has allowed service delivery to be maintained at relatively low cost, but also has emphasized the need for a broadened scope of activity. Hiring paraprofessionals has often provided a means of consumer input, allowing client-perceived needs to be voiced and further action to be taken to alleviate hardship. The resultant expansion of services and/or the inclusion of formerly unserved segments of the population, however, have recreated in effect a severe labor shortage. Because the economic base is not sufficient to support the training and hiring of complete staffs of paid professionals and paraprofessional workers, more and more agencies are using volunteers (Brown and Ishiyama 1968; Feinstein and Cavanaugh 1974; Fox

1973; Hayler 1975; Hinton and Sterling 1975; Mackenzie and Bruce 1972; Minor and Thompson 1975; Mounsey 1973; Nicoletti and Flater 1975; Roupe 1973; Routh 1972; Schindler-Rainman and Lippitt 1971; Schulman and Poole 1968; Silk 1972; Widdowson and Griffiths 1971).

Actual figures reflecting the savings resulting from using volunteers generally are not reported. The Law Enforcement Assistance Administration (LEAA), however, has conducted a survey of the use of volunteers in correctional and probation settings. They have estimated that the hours donated in 2 years have been worth more than $1.8 million (Law Enforcement Assistance Administration 1972). The Phoenix, Arizona, Center for the Blind, which uses approximately 350 persons in service delivery, provides another indication of the savings realized by using volunteers. In 1 year, these volunteers donated 25,000 hours of their time in more than 8,500 separate assignments. Based on the minimum wage, the savings to the center were estimated at $35,000 (Cull and Hardy 1974). Homecoming, a rehabilitation program which assists mental patients in making the transition from the hospital to the community, uses the services of volunteers extensively. Administrators of this program have estimated that volunteer services constitute a savings of at least $1,664 per year per patient (Hetherington and Rappeport 1967). One final example, from a crisis telephone counseling center, indicates that volunteer intervention accounts for 72 percent of service delivery, thereby reducing the costs of operation considerably (O'Donnell and George 1977).

Volunteers also have been used when the objective is not to decrease costs, but to maintain costs while improving treatment and service delivery or while expanding the current program to include additional services or formerly unserved populations (Burnis and Ackerly 1969; Ferry 1968; Arthur 1973; Fox 1973; Goddard and Jacobson 1967; MacBain 1975; Roupe 1973). In some instances, the primary concern has not been to reduce program costs or to maintain existing costs while increasing or improving services, but rather to provide service without cost (Beier et al. 1971; Fried and Dushkes 1972). In these cases, volunteer participation determines whether or not services will be available at all.

Quality of service. Because of the range of skills and abilities now available, volunteers have special qualifications that allow them to make unique human-service contributions (Holand and Voss 1968; Schindler-Rainman and Lippitt 1971). Also, the absence of both professional role expectations and an assigned status within the program or agency hierarchy are thought to allow volunteers a freedom of action and orientation denied to the professional or paraprofessional. The volunteers' enthusiasm, and the fact that they are not paid for the services they provide, add to their unique position within the treatment and service delivery system.

In both the mental health and corrections areas, it is argued that professionals are sometimes too overburdened with administrative details to provide the appropriate emotional support to their clients (Aves 1969; Goddard and Jacobson 1967). Using volunteers for tasks requiring less expertise frees professional staff from routine

duties and allows them more time to devot[illegible] direct treatment (Delworth et al. 1974; Ferry 1968; Fox 1973; [illegible]land and Voss 1968; Stoeckel et al. 1975).

Rationales Against Using Volunteers

Arguments against using volunteers in human services are common in the literature. However, this literature tends to be oriented toward problem solving, with criticisms and objections to the use of volunteers presented and then countered. The following statements seem to summarize the present rationales against the use of volunteers (Fried and Dushkes 1972; Mounsey 1973; Nicoletti and Flater 1975; Rayerson 1972; Routh 1972; Sata 1972; Schindler-Rainman and Lippitt 1971).

- Volunteers create more work than they are able to return in services; costs incurred by volunteers are hard to justify.
- Volunteers cannot handle serious problems.
- Volunteer programs attract a high ratio of middle-class persons, whereas clients tend to be drawn from lower social classes.
- Using volunteers denies the professional the rewards and satisfaction that come from client feedback.
- Volunteers cannot be expected, with relatively brief training, to perform the functions for which professionals spend years in training.
- Volunteers are unreliable, less interested, and less enthusiastic than professionals; they are unwilling to undertake tasks of lesser importance or to work with difficult clients.
- Volunteers are more interested in working out their own problems than in helping clients.
- Clients question the qualifications of volunteers and the payment of a fee for services received from unpaid personnel.

RECRUITMENT AND SELECTION OF VOLUNTEERS

Enlisting the aid of qualified volunteers is perhaps the most pressing concern of a program director or administrator wishing to establish or maintain a volunteer program. For this reason, sources of volunteers, recruitment techniques, and selection procedures are discussed below.

Volunteer Pools

There are specific groups within the population that have become increasingly involved in volunteer work. These groups include youths, college students, professionals, retirees and the elderly, indigenous persons, clients and ex-clients, and the handicapped.

Because they generally have few obligations vis-a-vis adults and because they are often eager to assume responsible roles, youths provide perhaps the most accessible source of volunteers. Although their relative lack of maturity, general knowledge, and varied experience may somewhat restrict the assignments or the programs for which youths can effectively volunteer, several authors have noted particular benefits derived from using them. For example, young "street wise" and "drug wise" volunteers have been used successfully in hospital emergency rooms and drug abuse clinics to "talk down" clients suffering from acute reactions to drugs (Gay et al. 1972; Termansen 1973). Their peer position and familiarity with the drug subculture encourage volunteer-client interaction and also serve to undercut clients' manipulation of professional staff (Gay et al. 1972). Youths also have demonstrated their enthusiasm for establishing and maintaining socially and emotionally supportive roles with mentally ill, mentally retarded, and emotionally disturbed patients (American Psychiatric Association 1973; Boylin 1973; Cowne 1970; Ewalt 1967; Glasmann and Turner 1967; Lavker and Rosett 1966; Rath 1973; Savage 1972), and with elderly, ill, or infirm persons (Bowden 1972; Cowne 1970; Mendelsohn and Gold 1968; Rubenstein and Rubenstein 1972; Squire 1973). They also have demonstrated a special competence when serving as tutors and peer counselors (Schmitt 1975; Varenhorst 1974).

Through their participation in activities such as civil rights campaigns, the Peace Corps, and educational programs for the disadvantaged, university students have gained the reputation of being actively concerned about society and individuals. Their enthusiasm, idealism, and altruism have encouraged their wide use in mental health programs and projects.[31] Their increased independence, maturity, and physical and mental abilities, in comparison with those of high school students, also enhance their usefulness for treatment service delivery programs.

Professionals, individuals who have obtained postgraduate degrees in disciplines relevant to treatment or service delivery, provide a unique manpower resource for programs and agencies. Although the time available to them for participation in volunteer activities

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[31]Beck et al. 1963, 1965; Bergman and Doland 1974; Brown and Ishiyama 1968; Brunell 1967; Burnis and Ackerly 1969; Cowne 1969; Doud and Regan 1965; Fischer 1970; Haddock and Dundon 1951; Holbrook 1974; Holzberg 1963; Holzberg et al. 1964a,b, 1966; Holzberg and Knapp 1965; Mitchell 1966b; Reyerson 1972; Siegel 1973; Spoerl 1968; Tyce 1970; Umberger et al. 1962; Wanderer and Sternlicht 1964; Witkin 1973; Wolff 1974.

is likely to be restricted, this group brings a level of expertise not found among more typical volunteers. For example, attorneys have often provided legal counsel to parolees, social workers, clergymen, and community workers. They also have established neighborhood legal assistance centers for the poor (Berman 1975; Leenhouts 1972, 1978; Savage and Wesson 1975; Shamberg 1968; Simmons 1975). Psychologists, psychiatrists, physicians, dentists, optometrists, etc., also have been reported to provide services to clients of the criminal justice system through the Volunteers in Prevention, Prosecution, Probation, Prison, and Parole (VIP) Program (Leenhouts 1978). In the area of health care, physicians are well known for donating their services to free clinics and in emergency situations (Amenta 1974; American Hospital Association 1973; Frank et al. 1969; Freiden et al. 1970; Hague 1969; Harkness and Dougherty 1968; Hughes et al. 1972).

Because retired persons and the elderly traditionally have been viewed as recipients of treatment and services, they were excluded from volunteer activities in the past (Babic 1972; Beverley 1975a; Friedman 1975; Sainer 1973b). In the early 1960s, however, in response to the report of the Joint Commission on Mental Illness and Health, the Federal Government initiated steps to develop volunteer resources on a national level. These steps included establishing such programs as the Foster Grandparent Program (FGP), the Retired Senior Volunteer Program (RSVP), and the Service Corps of Retired Executives (SCORE) (Babic 1972; Beverley 1975a, b; Blatchford 1974; Cowne 1970; Naylor 1972; Sainer 1971, 1972, 1973a,b). It was largely through service in these programs that the latent talents, the free time, and the value of experiences accumulated by retired and elderly persons were recognized on a grand scale (Sainer 1973b).

The indigenous person is another type of volunteer traditionally viewed as a recipient, rather than a provider, of treatment and services. Volunteers are generally considered to be "indigenous" when there is: (1) a similarity between the volunteer and the client population in terms of particular problems or illnesses and/or (2) a similarity between the volunteer and client population in terms of language, ethnic or racial background, culture, work experience, socioeconomic status, etc. Efforts to use such persons as volunteers recently have increased in response to professionals' evaluations of treatment and service delivery (Cooper 1967; Cull and Hardy 1974; Gay et al. 1972; Kleinman 1977; Siegel 1973; Silverman 1969; Sobey 1970; Termansen 1973). They reported:

- Enhanced communication, trust, and responsiveness between clients and volunteers with similar background experiences and lifestyles (Cooper 1967; Gay et al. 1972; Nurco 1972; Siegel 1973; Silverman 1969; Sobey 1970; Termansen 1973);

- Better social learning models for clients when indigenous volunteers were used rather than middle-class professionals or those inexperienced in regard to the client's particular problem or illness (Gay et al. 1972; Kleiman et al. 1977; Silverman 1969; Sobey 1970);

- A reduction in cultural, racial/ethnic, and socioeconomic barriers between the agency and the community when indigenous volunteers serve as a bridge between the professional and the client (Gay et al. 1972; O'Donnell and George 1977; Siegel 1973; Sobey 1970; Termansen 1973).

Indigenous volunteers have been used in drug abuse treatment programs (Gay et al. 1972; Termansen 1973), mental health projects (Cowne 1969; Siegel 1973), and social services (Cowne 1969; Gay et al. 1972; Silverman 1969; Sobey 1970).

Clients and ex-clients also have been used in the areas of corrections and mental health. Although their use is somewhat restricted due to their particular status as an inmate or a current or former psychiatric patient, several reports indicate that they have a unique perspective that can be effectively applied to counseling (e.g., the Lifers' Group at Rahway State Prison, New Jersey) (Abrams 1970; Collins 1967; Eiler 1972; Featherman and Welling 1971; Levine 1968; Szymanski and Fleming 1971). Inmates also have cared for retarded children (Eiler 1972) and men (Abrams 1970), while psychiatric outpatients have participated in advisory committees as volunteers attempting to improve overall program functioning (Sata 1972).

Because the handicapped in general are still perceived as recipients of services, their potential as volunteers remains largely undeveloped. However, it has been demonstrated that, with careful planning and preparation, these persons can successfully fulfill companionship roles, teach crafts, and make and repair equipment for service programs (K[illegible] 1973).

Recruitment Techniques

Unless the requirements of a particular program demand the exclusion of certain segments of the population, attempts to recruit volunteers should cover both sexes, all age groups, and all socioeconomic classes. This helps to insure that a broad range of skills and abilities will be available to the program and to its clients (Pell 1972; Routh 1972).

Commonly applied recruitment techniques include: lectures or guest appearances at various church groups and civic organizations (Berger et al. 1975; Covner 1969; Fox 1973; Frank et al. 1969; Law Enforcement Assistance Administration 1972; Pell 1972; Routh 1972; Wahler and Erickson 1969); announcements broadcast through mass media channels--such as radio, television, newspaper advertisements (Berger et al. 1975; Covner 1969; Fox 1973; Green 1971; Pell 1972; Routh 1972); lectures and workshops held on college campuses or as part of university classes (Berger et al. 1975; Green 1971; Law Enforcement Assistance Administration 1972; Pell 1972; Rapp and Primo 1974; Routh 1972); and the use of informal, word-of-mouth communication networks (Berger et al. 1975; Covner 1969; Fox 1973; Frank et al. 1969; Green 1971; Law Enforcement Assistance Administration 1972; Pell 1972; Routh 1972). If funding

permits, a general mailing of pamphlets or brochures explaining the prospective program and the need for volunteers can be conducted. On a more limited budget, these materials can be sent to appropriate community organizations and/or agencies. Application forms for potential volunteers can also be enclosed (Pell 1972; Routh 1972; Wahler and Erickson 1969). Still other authors have recommended enlisting indigenous leaders or people to act as liaisons between the program and the community to secure volunteers (Fox 1973; Routh 1972). This final procedure, however, would appear to restrict greatly the program director's or administrator's control over the type(s) of volunteers being recruited.

Selection Procedures

Although recruitment techniques have been relatively consistent across programs and treatment areas, selection criteria have varied widely. For example, in the area of juvenile corrections, some program directors believed that anyone who volunteered could be used in some capacity. The only selection criterion imposed was in regard to volunteers working directly with juveniles, and that criterion appeared quite lenient--i.e., that volunteers with problems potentially damaging to juveniles would be excluded from direct service roles (Fox 1973). In a comparable program, however, volunteers were selected only after a review of their references and an interview by two members of the court staff (Berger et al. 1975). An LEAA survey of selection procedures (1972) revealed that volunteers in correctional settings were generally required to complete an application form, that an interview was optional, and that references were seldom requested. Furthermore, the report indicated that program directors were interested in selecting volunteers who were members of minority groups, who did not have high values and rigid mores, and who were not so educated as to have difficulty in relating to inmates, parolees, and probationers (also Stoeckel et al. 1975).

In the mental health, social service, and educational fields, an interview is usually required before a volunteer is accepted into a program or project (Delworth et al. 1974; Green 1971; Pell 1972; Rapp and Primo 1974; Routh 1972). This interview is usually intended as a means of assessing the potential volunteer's motives for volunteering (Pell 1972; Rapp and Primo 1974) and his/her interests and level of commitment (Delworth et al. 1974; Pell 1972; Rapp and Primo 1974; Routh 1972). Various standardized psychological indices (e.g., the Minnesota Multiphasic Personality Inventory, the California Psychological Inventory, the Kuder Preference Record) have also been employed to measure the personality characteristics of potential volunteers (Covner 1969; Delworth et al. 1974; Schoenfeld et al. 1976).

Finally, Burnis and Ackerly (1969) suggested that program directors or personnel should provide volunteers with an opportunity to learn about the treatment or services provided by the agency; the characteristics of the community being served; the type of problems encountered by clients; and the role of the volunteer in relation

to the program, the clients, and the community. They believe that this is the most appropriate method of selecting volunteers who will remain committed to the program and/or its clientele.

TRAINING VOLUNTEERS

Programs or procedures instituted to train volunteers vary from infrequent inservice consultations with professional staff (Wahler and Erickson 1969) to formal curriculums. Most training programs, however, include several common elements. The first of these is an orientation session, or sessions, which are intended to provide the volunteer with an understanding of the program, clients, community, etc.

Many training programs provide the volunteers with a reading list or a manual or handbook to be used for reference in the future (Berger et al. 1975; Gelineau and Evans 1970; Hinton and Sterling 1975). Ongoing supervision and consultation in regard to the volunteer's assigned client have been found in many training programs as well (Berger et al. 1975; Burnis and Ackerly 1969; Fox 1973; Gelineau and Evans 1970; Green 1971; Law Enforcement Assistance Administration 1972; Pell 1972; Schmitt and Furniss 1975; Siepker et al. 1977; Silk 1972; Solomon and Horenstein 1974).

In attempting to outline an ideal volunteer training program, Routh (1972) listed several components that he considered to be essential. These included:

- Human relations or communication skills (also Gelineau and Evans 1970; Green 1971; Varenhorst 1974);
- A description of the program's goals, procedures, and purposes, and its relationship to other community agencies;
- A clear delineation of the volunteer's role, emphasizing the particular functions and activities that volunteers are expected to perform, as well as those that are reserved for professional or paid staff;
- References to services available throughout the community, as well as sources of referral for the agency;
- Instruction regarding the necessity for confidentiality;
- A description of the client population;
- A demonstration of the value of the volunteer as an aid to professional staff; and
- Continuing inservice training.

Routh stressed, however, that the education, qualifications, and experience of each group of volunteers should be assessed before

a particular training curriculum is initiated. With the changing patterns of volunteers' characteristics, skills, and abilities, such a strategy would allow the tailoring of training to fit the specific needs of volunteers, and ultimately result in cost efficiency as well as more effective volunteers.

RECOMMENDATIONS FOR THE DESIGN AND IMPLEMENTATION OF SUCCESSFUL VOLUNTEER PROGRAMS

Numerous case studies have detailed successful volunteer programs; certain factors seem to be related to successful use of volunteers. The first, and perhaps most essential, consideration is publicity.[32] The program or agency must inform the community of its intention to initiate a volunteer program. This not only serves as a means of recruiting volunteers, but also provides an opportunity for interested and qualified citizens to participate in the planning stages of the program and to provide information concerning the needs as well as the particular environmental and human resources available within the immediate area. Securing active community involvement and good will appear to be essential to establishing and implementing successful programs (Furedy and Kirschner 1975; Routh 1972; Smith and Reddy 1973).

Staff and community residents should cooperate in planning specific services to be offered clients (Siepker et al. 1977). Again, volunteers can provide valuable insights that help to insure that services will be relevant, that they will be used by the target population, and that they will be delivered in the most efficient manner possible. Plans for using personnel and job descriptions (including those of professional staff) should be developed along with the plans for potential services to insure that the program's objectives are realistic (Brown and Ishiyama 1968).

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[32]American Psychiatric Association 1973; Aud 1973; Beier et al. 1971; Bergman and Doland 1974; Blatchford 1973; Bleach and Claiborn 1974; Burrill 1966, 1969; Cole and Cole 1969; Covner 1979; Cowne 1970; Davis 1970; Driscoll 1971; Eiler 1972; Featherman and Welling 1971; Feinstein and Cavanaugh 1974; Gay et al. 1972; Greene and Mullen 1973; Greenbank and Cameron 1968; Goldstein 1966; Hilferty and Scott 1974; Holbrook 1974; Ingram and Swartsfager 1973; Kraft 1966; Lawry 1973; Leenhouts 1973; Mackenzie and Bruce 1972; Markoff 1969; Martz 1974; Minor and Thompson 1975; Morley 1976; Muro 1974; Nicoletti and Flater 1975; Nicoletti and Flater-Benz 1974; Rath and David 1973; Rich 1973; Rieger et al. 1969; Ryberg 1969; Sainer 1973a; Savage 1972; Schindler-Rainman 1971; Siegel 1973; Silk 1972; Silverman 1969; Simmons 1975; Smiley 1973; Smith 1973; Suarez and Ricketson 1974; Szymanski and Fleming 1971; Termansen 1973; Tyce 1970; Widdowson and Griffiths 1971; Wolff 1974.

Particular concerns in the development of job descriptions for volunteer staff must also be considered (Brown and Ishiyama 1968). Although understandably concerned both with agency needs and with accomplishing stated objectives, the staff should also consider the needs, talents, and skills of the volunteer (Furedy and Kirschner 1975; Hayler 1975; Pettinelli 1971; Pretzel 1970; Schulman and Poole 1968; Siepker et al. 1977; Smith and Reddy 1973). This process will be expedited if community residents and representatives of the potential volunteers are included in job description planning.

Although program objectives, specific services to be offered, and job descriptions are determined prior to initiation of the program, they must remain flexible. In fact, the first year or two of a new program is generally an experience in trial and error. The expected value of particular services may not materialize; client use of services may fluctuate considerably as community residents become increasingly aware of program offerings; and as increasing numbers of both clients and volunteers become affiliated with the program, demands will change. Unless the agency responds to these factors, even an ideally planned and implemented program can ultimately fail (Leenhouts 1978).

Another major consideration in establishing a successful volunteer program and insuring its continued success is the employment of a supervisor or coordinator of volunteer services (Furedy and Kirschner 1975; Katkin et al. 1975; Kotzen 1966; Pettinelli 1971; Michener and Walzer 1970; Schulman and Poole 1968; Siepker et al. 1977). Problems in implementing the volunteer program, problems associated with volunteer-client interaction, and problems concerning staff reactions both to volunteers and to volunteer-client interaction are likely to emerge. Unless these problems are handled with a sensitivity toward agency staff, volunteers, and clients, the potential effectiveness of the volunteer program can be undercut. The volunteer coordinator, then, serves as a bridge between the volunteer and the agency. S/he insures that volunteers are not overworked, that they are provided with rewarding experiences as volunteers, and that appreciation for their services is acknowledged in an appropriate and meaningful way (Furedy and Kirschner 1975; Pettinelli 1971; Routh 1972; Schulman and Poole 1968).

It also is important to provide opportunities for staff, volunteers, and clients to contribute to further program revisions. The actual strategy employed does not appear to be particularly important, as long as ideas and opinions can be expressed freely, are attributed some degree of importance, and are considered in future program development and revision (Furedy and Kirschner 1975; Hayler 1975; Pettinelli 1971; Naylor 1971; Routh 1972).

SUMMARY

The major reasons for initiating a volunteer program are said to be cost efficiency and quality of service. It has been documented

that using volunteers can allow a program with insufficient funding to continue providing treatment and services to clients, or to expand its target population and/or services without increasing its budget. The range of skills and abilities provided by volunteers, the absence of professional role expectations and an assigned professional status, and the enthusiasm of volunteers all contribute to an improvement in the quality of service provided.

Many segments of the population are becoming increasingly involved in volunteer activities. These groups include youths, university students, housewives, professionals, retired persons, the elderly, indigenous persons, clients, ex-clients, and the handicapped. Each of these groups has particular characteristics, abilities, or interests that make them likely candidates for volunteer roles.

Various techniques have been proposed for recruiting volunteers. The most common include lectures and guest appearances before university classes or community organizations, announcements through mass media networks, and word-of-mouth communication. All methods seem to be effective. The primary concern in recruiting volunteers is encouraging voluntarism among all segments of the population to insure that a range of skills and abilities are available to the program. The exception to this occurs when a particular program needs volunteers who possess specific characteristics or abilities.

Selection procedures are not always employed in the program setting. Some directors or administrators believe that everyone who applies can be used in some capacity. A greater number, however, believe that the volunteers' motives, level of commitment, and personal suitability for the treatment setting should be assessed. Although this is usually accomplished in an individual interview, some directors require psychological testing and references before they accept a volunteer into their program.

The minimum training provided to volunteers consists of inservice consultation with professional staff. Several other essential components have also been offered, including: instruction in human relations or communication skills, a description of program objectives and procedures, a clear delineation of the volunteer's role, and continuing inservice training.

The literature also offers several suggestions for initiating and maintaining a successful volunteer program. These include:

- Notifying the community of the intention to initiate a volunteer program;
- Including community members in all phases of planning and development;
- Considering the needs, talents, and skills of volunteers in developing job descriptions and assigning roles;

- Continuously reevaluating and modifying services, and staff and volunteer roles;
- Providing volunteers with appropriate training;
- Employing a supervisor or coordinator of volunteer services; and
- Keeping the channels of communication open among staff, volunteers, clients, and the community.

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Appendix

I. Community Education

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Provide general public information, e.g., in regard to programs and services or in regard to drug abuse, alcoholism, mental health, corrections, etc., in general.	Mackenzie and Bruce (1972)		American Psychiatric Assoc. (1973) Sata (1974)	Case and Henderson (1973) Law Enforcement Assistance Adm. (1972) Leenhouts (1973) Savage and Wesson (1975) U.S. Dept. of Health, Education and Welfare (1971)	Aves (1969) Bartow (1974) Blatchford (1973) Cain (1976) Cull and Hardy (1974) Goldstein (1966) Kohn (1973) Lawry (1973) Leppert (1973a,b) Levin (1973) MacBain (1975) Squire (1973)
Preparation of displays, newspaper/magazine articles, brochures, tapes, radio, and TV appearances.	Mackenzie and Bruce (1972) Markoff (1969)		American Psychiatric Assoc. (1973) Kraus (1967) Nicoletti and Flater-Benz (1974) Warren (1968)	Leenhouts (1973) Social and Rehabilitation Services (1969b)	Blatchford (1973) Cull and Hardy (1974) Goldstein (1966) Hubbell (1974) Lawry (1973) Leppert (1974) Levin (1973) MacBain (1975) Rich (1973) Routh (1972) Squire (1973)

I. Community Education (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Teach and advise community; arrange, conduct community workshops on drug abuse, alcoholism, mental health, corrections, etc., in general or in regard to specific services or programs.	Mackenzie and Bruce (1972) Markoff (1969) U.S. Dept. of Health, Education, and Welfare (1971)	Mounsey (1973)	American Psychiatric Assoc. (1973) Delworth et al. (1974) Greenbank and Cameron (1968) Grob (1967) Naylor (1971) Nicoletti and Flater-Benz (1974) Sata (1972) Siepker et al. (1977)	Goddard and Jacobson (1967) Leenhouts (1973) (1974) (1975) U.S. Dept. of Health, Education, and Welfare (1971)	Blatchford (1973) Cain (1976) Engs and Kirk Savage and Wesson Goldstein (1966) Lawry (1973) Squire (1973)
Interpret program to families of clients, to community.		Covner (1969)	Cole and Cole (1969) Epstein (1967) Kraus (1967) Naylor (1971) Nicoletti and Flater-Benz (1974) Ramsey (1972) Siegel (1973) Sobey (1970)	Fox (1973)	Cain (1976) Cull and Hardy 1974) Naylor (1974) U.S. Dept. of Health, Education, and Welfare (1971)
General public relations.	Markoff (1969)		Cowne (1970) Epstein (1967)	Case and Henderson (1973) Goddard and Jacobson (1967)	Cull and Hardy (1974) Goldstein (1966) Levin (1973)

II. Interagency Relationships

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Establish or maintain contacts with other agencies or with community organizations and/or resources.			Beier et al. (1971) Chaplan et al. (1966) Ewalt (1965) Nicoletti and Flater-Benz (1974) Schulman and Poole (1968) Sobey (1970)	Goddard and Jacobson (1967)	Cull and Hardy (1974) Frank et al. (1969) Goldstein (1966) Nolan (1977)
Develop or promote agency and/or community, State, National programs, services, or resources.	Davis (1970) Markoff (1969)	Manohar (1973) Mounsey (1973)	American Psychiatric Assoc. (1973) Beier et al. (1971) Blatt (1969) Burrill (1966) Chaplan et al. (1966) Christ (1967) Cohen (1966) Corning (1967) Grob (1967) Janzen (1974) Kraus (1967) Matarazzo (1970) Nicoletti and Flater-Benz (1974) O'Donnell and George (1977) Oppliger (1971) Ramsey (1972) Ryan (1965) Sainer and Kallan (1972) Sata (1972) Siepker et al. (1977) Sobey (1970)	Case and Henderson (1973) Eiler (1972) Fox (1973) Goddard and Jacobson (1967) Goter et al. (1969) Law Enforcement Assistance Adm. (1972) Leenhouts (1978) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Bartow (1974) Cain (1976) Cull and Hardy (1974) Duckman (1969) Frank et al. (1969) Freidin et al. (1970) Goldstein (1966) Harkness and Dougherty (1968) Hubbell (1974) Hughes et al. (1972) Kohn (1973) Lawry (1973) Leppert (1973a,b) Levin (1973) Naylor (1974) Nolan (1977) Thisse (1967)

II. Interagency Relationships (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Organize community groups, for example, for prevention of drug abuse, crime, mental illness, alcoholism; for community improvement; etc.	Rich (1973)		Ewalt (1965) Ramsey (1972) Sobey (1970)	Law Enforcement Assistance Adm. (1972)	Beverley (1975) Levin (1973) Nolan (1977) Rich (1973) U.S. Dept. of Health, Education, and Welfare (1971)
Coordinate agency, community, State, National programs or resources.	Davis (1970) Markoff (1969)		American Psychiatric Assoc. (1973) Greene and Mullen (1973) Matarazzo (1970) Nicoletti and Flater-Benz (1974) Warren (1968)	Case and Henderson (1973) Goddard and Jacobson (1967) Ingram and Swartsfager (1973) Law Enforcement Assistance Adm. (1972) Taylor et al. (1969)	Blatchford (1974) Cull and Hardy (1974) Frank et al. (1969) Lawry (1973)

III. Program Administration

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
General program or staff administration and supervision, for example, making up budgets, reviewing and revising program policies, evaluating effectiveness of services provided, scheduling staff assignments, and appointments.	Davis (1970 Markoff (1969)	Manohar (1973) Ryberg (1969)	American Pychiatric Assoc. (1973, 1977) Cohen (1966) Cowne (1970) Gelineau and Evans (1970) Levine (1968) Matarazzo (1970) O'Donnell and George (1977) Rath and David (1973) Sata (1972) Griffiths and Widdowson (1971)	Bryant(1972) Fox (1973) Goddard and Jacobson (1967) Leenhouts (1972, 1973, 1978) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Blatchford (1974) Byron (1974) Cull and Hardy (1974) Duckman (1969) Goldstein (1966) Hubbell (1974) Lawry (1973) Levin (1973) Nolan (1977) Routh (1972) Squire (1973)

III. Program Administration (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Obtain-and/or prepare facilities, equipment for client use.	Mackenzie and Bruce (1972) Termansen (1973)	Savage (1972)	American Psychiatric Assoc. (1973) Burrill (1966) Cohen (1966) Janzen (1974) Kallan (1973) Levine (1968) Michener and Walzer (1970) Minor and Thompson (1975) Oppliger (1971) Ramsey (1972) Rich (1973) Ryan (1966) Sainer and Kallan (1972) Sainer (1973a,b) Sata (1972) Savage (1972) Siegel (1973) Smiley (1973) Sobey (1970) Wiseman (1969)	Eiler (1972) Fox (1973) Goddard and Jacobson (1967) Hargadine (1969) Ingram and Swartsfager (1973) Law Enforcement Assistance Adm. (1972) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Bartow (1974) Blatchford (1974) Binkley et al. (1968) Cain (1976) Coles and Brenner (1968) Cull and Hardy (1974) Duckman (1969) Frank et al. (1969) Goldstein (1966) Healey (1973) Hubbell (1974) Kallan (1973) Kohn (1973) Leppert (1973a,b) Levin (1973) Nolan (1977) Rich (1973) Routh (1972) Squire (1973) Suarez and Ricketson (1974) Yawkey and Silvern (1975)

III. Program Administration (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Fundraising.	Markoff (1969) U.S. Department of Health, Education, and Welfare (1971)		American Psychiatric Assoc. (1973) Cowne (1970) Grob (1967) Michener and Walzer (1970) Oppliger (1971) Ramsey (1972) Rieger et al. (1969) Ryan (1966) Sata (1972) Schwartz (1970)	Fox (1973) Goddard and Jacobson (1967) Hargadine (1969) Law Enforcement Assistance Adm. (1972) Leenhouts (1973)	Bartow (1974) Cull and Hardy (1974) Green (1971) Hubbell (1974) Kohn (1973) Lawry (1973) Leppert (1973a,b) Levin (1973) Routh (1972) U.S. Dept. of Health, Education, and Welfare (1971)
Recruit staff, volunteers.			Cole and Cole (1969) Epstein (1967) Gelineau and Evans (1970) Hetherington and Rappeport (1967) Roth (1967) Sobey (1970)	Fox (1973) Goddard and Jacobson (1967) Law Enforcement Assistance Adm. (1972) Leenhouts (1973)	Aves (1969) Clark (1966) Freidin et al. (1970) Goldstein (1966) Harkness and Dougherty (1968) Kallan (1973) Leppert (1973a,b) Naylor (1974)
General consultation for programs, agencies, community.	Davis (1970) Markoff (1969)			Fox (1973) Law Enforcement Assistance Adm. (1972) Leenhouts (1973)	Aves (1969) Goldstein (1966) Lawry (1973) Thisse (1967)

III. Program Administration (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Inservice training of volunteers or counselors, for example, explaining procedures and rules to new staff members, participating as instructors in training programs.	Davis (1970) Markoff (1969)	Manohar (1973)	Cowne (1970) Delworth et al. (1974) Eisenstein (1969) Gelineau and Evans (1970) Hetherington and Rappeport (1967) Naylor (1971) O'Donnell and George (1977) Schulman and Poole (1968)	Case and Henderson (1973) Fox (1973) Goddard and Jacobson (1967)	Byron (1974) Duckman (1969) Leppert (1973a,b) Levin (1973)
Recordkeeping, for example, filling out forms which deal with client admission, progress, and/or discharge.	Markoff (1969) U.S. Dept. of Health, Education, and Welfare (1971)		Bergman and Doland (1974) Martz (1974) Rath and David (1973)	U.S. Dept. of Health, Education, and Welfare (1971)	Aud (1973) Leppert (1973a,b) Routh (1972)
Report writing, for example, writing accounts of interactions with clients, informing counselors or supervisors of activities conducted with clients.			Cowne (1970) Green (1971) Hayler (1975) Hetherington and Rappeport (1967) Hinton and Sterling (1975) Holand and Voss (1968) Schulman and Poole (1968)	Ellenbogen and DiGregorio (1975) Stoeckel et al. (1975)	Aud (1973) Goldstein (1966)

III. Program Administration (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Messenger.		Driscoll (1971)	Levine (1968) Malhotra and Olgiati (1977) Widdowson and Griffiths (1971)	Case and Henderson (1973) Fox (1973) Goddard and Jacobson (1967)	Binkley et al. (1968) Frank et al. (1969) Routh (1972)
Receptionist.	American Hospital Assoc. (1973) Markoff (1969) U.S. Dept. of Health, Education, and Welfare (1971)		American Psychiatric Assoc. (1977) Featherman and Welling (1971) Holand and Voss (1968) Roth (1967) Sata (1974) Sobey (1970) Widdowson and Griffiths (1971)	Fox (1973) Goddard and Jacobson (1967)	Aves (1969) Binkley et al. (1969) Levin (1973) Routh (1972) U.S. Dept. of Health, Education, and Welfare (1971)
Cleaning and/or maintenance and repair of equipment, building, or grounds.	Markoff (1969) Morley (1976) U.S. Dept. of Health, Education, and Welfare (1971)	Savage (1972)	Cowne (1970) Kotzen (1966) Levine (1968) Minor and Thompson (1975) Ramsey (1972) Savage (1972)	U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Beverley (1975) Clark (1966a,b) Coles and Brenner (1968) Healey (1973a,b) Keating et al. (1973) Kohn (1973) Sainer (1973)

III. Program Administration (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
General secretarial and clerical tasks.	American Hospital Assoc. (1973) Markoff (1969)		Cowne (1970) Hallowitz (1968) Levine (1968) Malhotra and Olgiati (1977) Manasa (1973) Ramsey (1972) Roth (1967) Sata (1974) Schulman and Poole (1968)	Case and Henderson (1973) Fox (1973) Goddard and Jacobson (1967) Law Enforcement Assoc. Adm. (1972) Social and Rehabilitation Service (1969a)	Aves (1965) Binkley et al. (1968) Cull and Hardy (1974) Goldstein (1966) Lawry (1973) Leppert (1973a,b) Levin (1973) MacBain (1975) Routh (1972) Sainer (1973a,b) Yawkey and Silvern (1975)

IV. Counseling in the Community

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Outreach, casefinding--i.e., visit homes, families, neighborhoods to motivate persons in need to seek help, to extend treatment or services.	Gay (1972) Morley (1976)	Manohar (1973)	American Psychiatric Assoc. (1975) Beck and Gelineau (1963) Cain and Epstein (1967) Christ (1967) Cole and Cole (1969) Collins (1967) Corning (1967) Featherman and Welling (1971) Haylor (1975) Hinton and Sterling (1975) Kraus (1967) Naylor (1971) Nicoletti and Flater-Benz (1974) Sata (1974) Siegel (1973) Silverman (1969) Sobey (1970) Watson et al. (1975)	Berger et al. (1975) Bryant (1972) Ellenbogen and DiGregorio (1975) Hubbell (1974) Simmons (1975) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Cull and Hardy (1974) Goldstein (1966) Kallan (1973) Kohn (1973) Lawry (1973) Morley (1976) Naylor (1974) Nolan (1977) Routh (1972) Squire (1973)
Observe and assess community problems, client needs.	Gay (1972) Mackenzie and Bruce (1972)		American Psychiatric Assoc. (1973) Christ (1967) Cole and Cole (1969) Martz (1974) Nicoletti and Flater-Benz (1974) Nicoletti and Flater (1975) Sobey (1970)	Beckman (1972) Goddard and Jacobson (1970) Ingram and Swartsfager (1973) U.S. Dept. of Health, Education, and Welfare (1971)	Coles and Brenner (1968) Cull and Hardy (1974) Duckman (1969) Frank et al. (1969) Leppert (1973a,b) Squire (1973)

IV. Counseling in the Community (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Crisis intervention.	American Hospital Assoc. (1973) Mackenzie and Bruce (1972) Termansen (1973) U.S. Dept. of Health, Education, and Welfare (1971)		Frederick (1972) Hague (1969) Hinton and Sterling (1975) Holand and Voss (1968) Janzen (1974) Jones (1968) Shore et al. (1972) Siegel (1973) Sobey (1970) Weis and Seiden (1974)	Goddard and Jacobson (1967) Goter et al. (1969) Law Enforcement Assistance Adm. (1972) Leenhouts (1973)	Aves (1969) Engs and Kirk (1974) Frank et al. (1969) Keating et al. (1973) U.S. Dept. of Health, Education, and Welfare (1971)

V. Control and Enforcement

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Investigation/surveillance.				Ellenbogen and DiGregorio (1975) Hubbell (1974) Leenhouts (1972, 1974) Social and Rehabilitation Service (1969a) Stoeckel et al. (1975)	
Locate clients.	Mackenzie and Bruce (1973) Termansen (1973)				
Maintain contact with clients, followup, aftercare.	Gay et al. (1972) Gelineau (1967) Markoff (1969) Termansen (1973)	Ryberg (1969)	American Psychiatric Assoc. (1975) Beck and Gelineau (1963) Corning (1967) Cowne (1970) Epstein (1967) Gelineau (1967) Grob (1967) Hodgeman (1974) Katkin et al. (1975) Kotzen (1966) Kraus (1967) Nicoletti and Flater-Benz (1974) Pamsey (1972) Rath and David (1973) Sainer and Kallan (1972) Sobey (1970)	Barr (1971) Bryant (1972) Case and Henderson (1973) Law Enforcement Assistance Adm. (1972) Leenhouts (1973) Mounsey (1973) Savage and Wesson (1975) Silk (1972) U.S. Dept. of Health, Education, and Welfare (1971)	Aud (1973) Kallan (1973) MacBain (1975)

V. Control and Enforcement (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Supervise clients, e.g., controlling and coordinating client traffic or disciplining clients.	Boudin et al. (1977) Davies (1970) Markoff (1969)	Ryberg (1969)	Katkin et al. (1975) Levine (1968) Malhotra and Olgiati (1977) McGavern (1967) Ramsey (1972) Shore et al. (1972) Siepker et al. (1977) Spoerl (1968)	Goter et al. (1969) Ku et al. (1975) Law Enforcement Assistance Adm. (1975) Social and Rehabilitation Services (1969d)	Clark (1966a,b) Cull and Hardy (1974) Goldstein (1966) Routh (1972) Yawkey and Silve (1975)

VI. Client Administration

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Evaluation/diagnosis of clients' problems (independently or through staff discussion), observation.	Davis (1970) Gay et al. (1972) Mackenzie and Bruce (1972) Markoff (1969)		Cowne (1970) Delworth et al. (1974) Hayler (1975) Hetherington and Rappeport (1967) Holand and Voss (1968) Katkin et al. (1975) Kraus (1967) Mitchener (1970 Polak and Kirby (1976) Reding and Goldsmith (1967) Schulman and Poole (1968) Sobey (1970) Wahler and Erickson (1969)	Ellenbogen and DiGregorio (1975) Goddard and Jacobson (1967) Leenhouts (1973) Social and Rehabilitation Services 1969b,d)	Amenta (1974) Goldstein (1966) Kohn (1973) Rich (1973)
Design or prescribe treatment or services for clients (independently or through staff discussion).	Davis (1972) Markoff (1969)		Cole and Cole (1969) Cowne (1970) Evans and Goldberg (1970) Hayler (1975) Hodgman and Stein (1966) Hubka et al. (1974) Rapp and Primo (1974) Rath and David (1973) Siegel (1973) Smiley (1973) Sobey (1970) Wahler and Erickson (1969)		Goldstein (1966) Holbrook (1974) Rich (1973)

VI. Client Administration (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Intake evaluation, screening; intake interview.	U.S. Dept. of Health, Education, and Welfare (1971)		Bergman and Doland (1974) Holand and Voss (1968) Kraft (1966) Kraus (1967) Sobey (1970)	Law Enforcement Assistance Adm. (1972) Social and Rehabilitation Service (1969a)	Amenta (1974) Engs and Kirk (1974) Naylor (1974) U.S. Dept. of Health, Education, and Welfare (1971)
Interpret client language, behavior.			Sainer (1962) Schulman and Poole (1968) Sobey (1970)		Aves (1969)
Refer clients to appropriate programs or agencies.	Mackenzie (1972)	Manohar (1973)	American Psychiatric Assoc. (1975) Beier et al. (1971) Cole and Cole (1969) Cooper and Southard (1966) Greenbank and Cameron (1968) Hague (1969) Hinton and Sterling (1975) Jarmusz (1969) Jones (1968) King (1971) Michener (1970) Siepker et al. (1977) Slaikeu et al. (1975) Tapp et al. (1974)	Case and Henderson (1973) Hubbell (1974) Law Enforcement Assistance Adm. (1972)	Cull and Hardy (1974) Engs and Kirk (1974) Frank et al. (1969) Freidin et al. (1970) Harkness and Dougherty (1968) Hughes et al. (1972) Lawry (1973) Naylor (1974) U.S. Dept. of Health, Education, and Welfare (1971)

. Client Administration (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
aison between clients and aff, community.	Mackenzie (1972) Termansen (1973)		Cohen (1966) Cooper and Southard (1966) Evans and Goldberg (1970) Gelineau and Evans (1970) Nicoletti and Flater-Benz (1974) Oppliger (1971) Redding and Goldsmith (1967) Shore et al. (1972) Siepker et al. (1977) Sobey (1970) Spoerl (1968)	Goddard and Jacobson (1967) Mounsey (1973) Social and Rehabilitation Service (1969b,d) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Cull and Hardy (1974) Freidin et al. (1970) Holbrook (1974) Lawry (1973) Leppert (1973a,b) Squire (1973) Suarez and Ricketson (1974)
ssist staff in providing eatment, services.		Driscoll (1971) Manohar (1973)	American Psychiatric Assoc. (1973) Beier et al. (1971) Burrill (1966) Cooper (1967) Cooper and Southard (1966) Cowne (1970) Malhotra and Olgiati (1977) Minor and Thompson (1975) Mitchell (1966) Oppliger (1971) Reyerson (1972) Rich (1973) Rieger et al. (1969) Ryan (1966) Sobey (1970) Varenhorst (1974)	Cowne (1970) Goddard and Jacobson (1967) Ingram and Swartsfager (1973) Mounsey (1973) Solomon and Horenstein (1974)	Aves (1969) Binkley et al. (1968) Clark (1966) Cowne (1966) Cull and Hardy (1974) Goldstein (1966) Hladky (1969) Levin (1973) Routh (1972) Sainer (1973a,b) Squire (1973) Suarez and Ricketson (1974)

VII. Personal Aid to Clients

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Provide role model.	Markoff (1969)		Grob (1967) Hayler (1975) Herman (1976) Nicoletti and Flater-Benz (1974) Oppliger (1971) Paterson and Paterson (1967) Sobey (1970)	Ellenbogen and DiGregorio (1975) Ku et al. (1975) Mounsey (1973) Social and Rehabilitation Service (1969b,d)	Goldstein (1966) Rich (1973) Suarez and Ricketson (1974)
Provide information, interpret program/services to clients.	American Hospital Assoc. (1973) Borenstein (1971) Markoff (1969)		Cole and Cole (1969) Cooper (1967) Fried and Dushkes (1972) Friedman (1975) Hayler (1975) Honton and Sterling (1975) Kleiman et al. (1977) Siepker et al. (1970) Silverman (1969)	Hubbell (1974) Ingram and Swartsfager (1973) Savage and Wesson (1975) Simmons (1975)	Aud (1973) Aves (1969) Coles and Brenner (1968) Cull and Hardy (1974) Duckman (1969) Engs and Kirk (1974) Goldstein (1966) Leppert (1973b) Levin (1973) Naylor (1974) Suarez and Ricketson (1974) U.S. Dept. of Health, Education, and Welfare (1971)

VII. Personal Aid to Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Assist clients in securing employment, financial assistance, housing, medical and dental care, legal aid, education, training, etc.	Gay et al. (1972) Gelineau (1967) Markoff (1969) U.S. Dept. of Health, Education, and Welfare (1971)		Beck et al. (1963) Corning (1967) Cowne (1970) Epstein (1967) Featherman and Welling (1971) Feinstein et al. (1974) Gelineau and Evans (1970) Hayles (1975) Herman (1976) Hinton and Sterling (1975) Hodgman and Stein (1966) Hubka et al. (1974) Kallan (1973) Katkin and Zimmerman (1975) Kotzen (1966) Levine (1968) Oppliger (1971) Ramsey (1972) Ryan (1966) Sainer and Kallan (1972) Siegel (1973) Silverman (1969) Smiley (1973) Sobey (1970)	Bryant (1972) Case and Henderson (1973) Fox (1973) Goddard and Jacobson (1967) Goter et al. (1969) Hubbell (1974) Law Enforcement Assistance Adm. (1972) Leenhouts (1973) Savage and Wesson (1975) Simmons (1975) Social and Rehabilitation Service (1971) Taylor et al. (1969) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Beverley (1975) Blatchford (1973) Duckman (1969) Goldstein (1966) Kallan (1973) Kohn (1973) Leppert (1973a,b) Levin (1973) Morley (1976) Naylor (1974) Routh (1972) Suarez and Ricketson (1974) Thisse (1967) U.S. Dept. of Health, Education, and Welfare (1971)

VII. Personal Aid to Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Secure services for clients.			Cain and Epstein (1967) Herman (1976) Schulman and Poole (1968) Siegel (1973)	Bryant (1972) Simmons (1975)	Lawry (1973) Leppert (1973a,b) Levin (1973) Suarez and Ricketson (1974)

VII. Personal Aid to Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Provide concrete services to clients, for example, homemaking, direct care, transportation, etc.	Gay et al. (1972) Mackenzie and Bruce (1972) Markoff (1969) Morley (1967)	Driscoll (1971)	Abrams (1970) American Psychiatric Assoc. (1973) Corning (1967) Cowne (1970) Featherman and Welling (1971) Fried and Dushkes (1972) Hayler (1975) Hinton and Sterling (1975) Hodgman and Stein (1966) Kallan (1973) Kotzen (1966) Kraus (1967) Levine (1968) Michener and Walzer (1970) Naylor (1971) Ramsey (1972) Sainer (1973) Schulman and Poole (1968) Siegel (1973) Smiley (1973) Sobey (1970) Tyce (1970) Watson et al. (1975) Widdowson and Griffiths (1971)	Berger et al. (1975) Bryant (1972) Case and Henderson (1973) Fox (1973) Goddard and Jacobson (1967) Goter et al. (1969) Hargadine (1969) Hubbell (1974) Ingram and Swartsfager (1973) Leenhouts (1973)	Aves (1967) Clark (1966a,b) Cull and Hardy (1974) Duckman (1969) Goldstein (1966) Healey (1973) Hubbell (1974) Kallan (1973) Kohn (1973) Lawry (1973) Leppert (1973a) Mendelsohn and Gold (1968) Routh (1972) Suarez and Ricketson (1974) U.S. Dept. of Health, Education, and Welfare (1971)

VII. Personal Aid to Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Provide social and emotional support to clients.	Gay et al. (1972 Markoff (1969) Morley (1976) Termansen (1973)	Driscoll (1971) Ryberg (1969)	Cain (1967) Cole and Cole (1969) Cowne (1970) Fried and Dushkes (1972) Friedman (1975) Hague (1969) Hayler (1975) Hodgman and Stein (1966) Karowe (1967) Katkin et al. (1975) Kleiman et al. (1975) Naylor (1971) Oppliger (1971) Ramsey (1972) Reding and Goldsmith (1967) Rich (1973) Sainer (1973a,b) Shore et al. (1972) Siegel (1972) Silverman (1969) Sobey (1970) Spoerl (1968)	Bryant (1972) Ellenbogen and DiGregorio (1975) Horejsi (1972) Leenhouts (1973) Mounsey (1973) Poorkaij and Bockelman (1973) Savage and Wesson (1975)	Aud (1973) Aves (1969) Blatchford (1974) Cull and Hardy (1974) Engs and Kirk (1974) Goldstein (1966) Healey (1973) Kallan (1973) Lawry (1973) MacBain (1975) Naylor (1974) Squire (1973) Suarez and Ricketson (1974)

VII. Personal Aid to Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Teach and advise clients; tutoring.	Manasa (1973) Markoff (1969) U.S. Dept. of Health, Education, and Welfare (1971)	Covner (1969)	American Psychiatric Assoc. (1973) Blatt (1969) Burnis and Ackerly (1969) Chaplan et al. (1966) Collins (1967) Corning (1967) Cowne (1970) Faulkner (1975) Featherman and Welling (1971) Hayler (1975) Herman (1976) House (1968) Hubka et al. (1974) Kallan (1973) Karowe (1967) Kraus (1967) Manasa (1973) McGavern (1967) Michener and Walzer (1970) Naylor (1971) Nicoletti and Flater-Benz (1974) Oppliger (1971) Ramsey (1972) Rath and David (1973) Rieger et al. (1969) Roth (1967) Sainer (1972, 1973a,b) Schulman and Poole (1968)	Berger et al. (1975) Bryant (1972) Case and Henderson (1973) Eiler (1972) Ellenbogen and DiGregorio (1975) Fox (1973) Goddard and Jacobson (1967) Hargadine (1969) Hubbell (1971) Law Enforcement Assistance Adm. (1972) Leenhouts (1973) Manasa (1973) Mounsey (19[illegible] Social and R[illegible]tation Service (1969a,d) Szymanski and Fleming (1971) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Beverley (1975) Blatchford (1974) Cain (1976) Clark (1966a,b) Coles and Brenner (1968) Cull and Hardy (1974) Duckman (1969) Eiler (1972) Ferry (1968) Freund (1971) Goldstein (1966) Healey (1973) Hilferty and Scott (1974) Holbrook (1974) Hubbell (1974b) Kallan (1973) Kohn (1973) Lear (1972) Leppert (1973a,b) Levin (1973) MacBain (1975) Manasa (1973) Muro (1974) Oppliger (1971) Rich (1973) Routh (1972) Schmitt and Furniss (1975) Squire (1973) Sulds and Kirschner (1975)

VII. Personal Aid to Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Teach and advise clients; tutoring. (Continued)			(Continued) Siegel (1973) Siepker et al. (1977) Silverman (1969) Smiley (1973) Snyder (1975) Sobey (1970) Tyce (1970) Verenhorst (1974) Watson et al. (1975)		(Continued) U.S. Dept. of Health, Education, and Welfare (1971) Yawkey and Silvern (1975)
Intervention on behalf of clients, for example, visiting clients at work, accompanying them on job interviews, visiting them in the hospital, appearing for them in court.		Driscoll (1971)	Cowne (1970) Naylor (1971) Sata (1972) Siegel (1973)	Bryant (1972) Case and Henderson (1973) Fox (1973) Hubbell (1974) Leenhouts (1973) U.S. Dept. of Health, Education, and Welfare (1971)	Aud (1973) Aves (1969) Cull and Hardy (1974) Healey (1973) Kallan (1973) Lawry (1973) Levin (1973) Naylor (1974) Sainer (1973a,b) Schindler-Rainman (1971) Suarez and Ricketson (1974)

VIII. Socializing with Clients

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Conduct recreational programs, group activities.	Markoff (1969) Roupe (1973		Abrams (1970) American Psychiatric Assoc. (1973) Beck et al. (1965) Blatt (1969) Brunell (1967) Burrill (1966, 1969) Burnis (1969) Christ (1967) Collins (1967) Corning (1967) Cowne (1970) Delworth et al. (1974) Eiler (1972) Faulkner (1975) Featherman and Welling (1971) Feinstein and Cavanaugh (1974) Fried and Dushkes (1972) Gelineau (1967) Greenbank and Cameron (1968) Hague (1969) Hayler (1975) House (1968) Hushka et al. (1974) Kallan (1973) Katzen (1966) Kraus (1967) Lavker and Rosett (1966)	Bryant (1972) Case and Henderson (1973) Eiler (1972) Ellenbogen and DiGregorio (1975) Fox (1973) Goddard and Jacobson (1967) Hargadine (1969) Ingram and Swartsfager (1973) Leenhouts (1973) Silk (1972) Social and Rehabilitation Service (1969a,b) U.S. Dept. of Health, Education, and Welfare (1971)	Binkly et al. (1968) Clark (1966a,b) Cull and Hardy (1974) Goldstein (1966) Green (1971) Holbrook (1974) Kallan (1973) Lawry (1973) Leppert (1973a) Muro (1974) Nolan (1977) Rich (1973) Routh (1972) Schmitt and Furniss (1975) Squire (1973) Yawkey and Silvern (1975)

VIII. Socializing with Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Conduct recreational programs, group activities. (Continued)			(Continued) Lear and Lewington (1974) LeVine (1966) Levine (1968) McGavern (1967) Minor and Thompson (1975) Naylor (1971) Nicoletti and Flater-Benz (1974) Patterson and Patterson (1967) Ramsey (1972) Rapp and Primo (1974) Rath and David (1973) Reding and Goldsmith (1967) Remar (1967) Rieger et al. (1969) Roth (1967) Sainer (1973a,b) Sainer and Kallan (1972) Sata (1972, 1974) Schulman and Poole (1968) Schwartz (1977) Siegel (1973) Siepker et al. (1970) Smiley (1973) Sobey (1970) Spoerl (1968) Tyce (1970) Varenhorst (1974) Watson et al. (1973) Wiseman (1969) Wolff (1974)		

VIII. Socializing with Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Escort clients on trips, tours, etc.	Morley (1976)		American Psychiatric Assoc. (1973) Beck et al. (1965) Blatt (1969) Burnis (1969) Collins (1967) Cowne (1970) Ewalt (1965) Faulkner (1975) Feinstein et al. (1974) Fried and Dushkes (1972) Herman (1976) Hetherington and Rappeport (1967) House (1968) Hubka et al. (1974) Kotzen (1966) Kraus (1967) Lavker and Rosett (1966) Naylor (1971) Patterson and Patterson (1967) Ramsey (1972) Rath and David (1973) Roth (1967) Schwartz (1970) Tyce (1970) Watson et al. (1975) Wiseman (1969)	Berger et al. (1975) Case and Henderson (1973) Fox (1973) Goddard and Jacobson (1967) U.S. Dept. of Health, Education, and Welfare (1971)	Binkly et al. (1968) Clark (1966a) Cull and Hardy (1974) Goldstein (1966) Lawry (1973) Leppert (1973) Rich (1973) Routh (1972) Squire (1973) Yawkey and Silvern (1975)

VIII. Socializing with Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Serve as a companion, friend, sponsor.	Ramsey (1972)		American Psychiatric Assoc. (1973) Arthur et al. (1973) Beck et al. (1965) Bergman and Doland (1974) Boylin (1973) Brunell (1967) Burnis and Ackerly (1969) Burrill (1966) Chinsky and Rappaport (1970) Cohen (1966) Cowne (1970) Evans (1970) Ewalt (1965) Fischer (1970) Gelineau (1967) Gelineau and Evans (1970) Green (1971) Hetherington and Rappeport (1967) House (1968) Kallan (1973) Karowe (1967) King et al. (1970) Kotzen (1966) Kraus (1967) Kulik et al. (1969) Michener and Walzer (1970) Mitchell (1966a,b) Naylor (1971)	Barr (1971) Berger et al. (1975) Berman (1975) Bryant (1972) Fox (1973) Goter et al. (1969) Hargadine (1969) Horejsi (1972) Ku et al. (1975) Leenhouts (1972, 1973) Mounsey (1973) Savage and Wesson (1975) Simmons (1975) Social and Rehabilitation Service (1969a) Solomon and Horenstein (1974) Szymanski and Fleming (1971) Taylor et al. (1969) U.S. Dept. of Health, Education, and Welfare (1971)	Arthur (1973) Aves (1969) Blatchford (1974) Coles and Brenner (1963) Cull and Hardy (1974) Kallan (1973) Kohn (1973) Mendelsohn and Gold (1968) Muro (1974) Naylor (1974) Oppliger (1971) Routh (1972) Schmitt and Furniss (1975) Suarez and Ricketson (1974) Sulds and Kirschner (1975) U.S. Dept. of Health, Education, and Welfare (1971)

VIII. Socializing with Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Serve as a companion, friend, sponsor. (Continued)			(Continued) Patterson (1967) Ramsey (1972) Rath and David (1973) Rich (1973) Sainer and Kallan (1972) Schwartz (1970) Shipley (1976) Siegel (1973) Silverman (1969) Smiley (1973) Snyder (1975) Sobey (1970) Varenhorst (1974) Watson et al. (1975) Witkin (1973)		

VIII. Socializing with Clients (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Arrange for, provide entertainment for clients.	Morley (1976)		American Psychiatric Assoc. (1973) Beck et al. (1965) Burrill (1966a,b) Collins (1967) Ewalt (1965) Featherman and Welling (1971) Feinstein and Cavanaugh (1974) Fried and Dushkes (1972) Hetherington and Rappeport (1967) Kallan (1973) Lavker and Rosett (1966) Levine (1968) Morley (1976) Oppliger (1971) Ramsey (1972) Rieger et al. (1969) Tyce (1970) Varenhorst (1974) Wiseman (1969)	Eiler (1972) Fox (1973) Goddard and Jacobson (1967) Hargadine (1969) Ingram and Swartsfager (1973)	Aves (1969) Clark (1966a,b) Cull and Hardy (1974) Green (1971) Kallan (1973) Lawry (1973) Leppert (1973a) MacBain (1975) Morley (1976) Nolan (1977) Routh (1972) Sulds and Kirschner (1975) Yawkey and Silvern (1975)

IX. Psychological/Psychiatric Services

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Administer psychological tests or appraisal instruments; scoring.		Driscoll (1971)	Bergman and Doland (1974) Schulman and Poole (1968) Siepker et al. (1977)	Goter et al. (1969) Leenhouts (1973)	Cull and Hardy (1974) Levin (1973)
Interpret psychological tests or appraisal instruments.				Leenhouts (1973)	
Psychotherapy.			Krebs (1971) Ramsey (1972)	Leenhouts (1972)	
Individual and/or group counseling.	Boudin et al. (1977) Gay et al. (1972) Mackenzie and Bruce (1972) Markoff (1969) U.S. Dept. of Health, Education, and Welfare (1971)	Covner (1969) Ferneau and Paine (1972) Madden and Kenyon (1975) Manohar (1973) Van Meulebrouck (1973)	American Psychiatric Assoc. (1977) Beck et al. (1963) Beier et al. (1971) Cooper (1967) Cowne (1970) Delworth et al. (1974) Featherman and Welling (1971) Feinstein et al. (1974) Heilig et al. (1968) Holand and Voss (1968) Kleiman et al. (1977) Polak and Kirby (1976) Nicoletti and Flater-Benz (1974) Sata (1974) Schulman and Poole (1968) Siegel (1973) Siepker et al. (1977) Sobey (1970)	Berger et al. (1975) Case and Henderson (1973) Ellenbogen and DiGregorio (1975) Fox (1973) Goter et al. (1969) Hargadine (1969) Horejsi (1973) Ingram and Swartsfager (1973) Ku et al. (1975) Law Enforcement Assist. Adm. (1972) Leenhouts (1972, 1973) Silk (1972) Social and Rehabilitation Service (1969b) Szymanski and Fleming (1971) U.S. Dept. of Health, Education, and Welfare (1971)	Aves (1969) Cull and Hardy (1974) Leppert (1973a) U.S. Dept. of Health, Education, and Welfare (1971)

IX. Psychological/Psychiatric Services (Continued)

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Telephone hotline, crisis intervention.	Mackenzie (1972)		American Psychiatric Assoc. (1975) Bleach and Clairborn (1974) Evans (1976) Greene and Mullen (1973) Heilig et al. (1968) Holand and Voss (1968) Jamison and Johnson (1975) Jarmusz (1969) King (1971) McGee and Knickerbocker (1972) O'Donnell and George (1977) Pederson and Babigian (1972) Pretzel (1970) Ramsey (1972) Schoenfeld and Neal (1976) Siegal (1973) Slaikeu et al. (1975) Tapp et al. (1974) Walfish et al. (1976)	Ingram and Swartsfager (1973) Law Enforcement Assistance Adm. (1972)	Aves (1969) Engs and Kirk (1974) Frank et al. (1969) Healey (1973) Routh (1972) U.S. Dept. of Health, Education, and Welfare (1971)

X. Medical/Dental Services

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Intake medical or dental examinations; perform diagnostic or laboratory tests.	Borenstein (1971) Davis (1970)		Hague (1969)	Goter et al. (1969) Law Enforcement Assistance Adm. (1972)	Amenta (1974) Frank et al. (1969) Freidin et al. (1970) Harkness and Dougherty (1968) Hughes et al. (1972)
Provide medical or dental care to clients in treatment.	American Hospital Assoc. (1973) Borenstein (1971) Davis (1970) Markoff (1969) U.S. Dept. of Health, Education, and Welfare (1971)		Michener and Walzer (1970) Sobey (1970)	Leenhouts (1972, 1978) Social and Rehabilitation Service (1969b)	Amenta (1974) Blatchford (1974) Frank et al. (1969) Freidin et al. (1970)
Prescribe and/or administer medication to clients.	Gay et al. (1972) Mackenzie and Bruce (1972) Markoff (1969)		Nicoletti and Flater-Benz (1974)		Amenta (1974) Frank et al. (1969) Freidin et al. (1970)
Prepare medical or dental supplies for program, client use.					Aves (1969) Cull and Hardy (1974) Frank et al. (1969) Kallan (1973) Lawry (1973)

XI. Legal Services

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Defend clients in court.				Hubbell (1974) Shamberg (1968)	
Consult with clients about their legal problems.	U.S. Department of Health, Education, and Welfare (1971)			Case and Henderson (1973) Law Enforcement Assistance Adm. (1972) Leenhouts (1978) Shamberg (1968) Simmons (1975)	Duckman (1969)
Advise members of the staff about legal issues concerning the program and/or the clients.					Cull and Hardy (1974) Lawry (1973) Thisse (1967)

XII. Research

Functions and activities	Drug abuse	Alcoholism	Mental health	Corrections	Other
Design, implement and/or direct research projects.			Nicoletti and Flater-Benz (1974) Nicoletti and Flater (1975) Warren (1968)	Fox (1973) Leenhouts (1973)	Nolan (1977)
Interviewing, data collection and processing.			Sata (1972, 1974) Schulman and Poole (1968) Tapp et al. (1974) Varenhorst (1974)	Fox (1973) Goddard and Jacobson (1967)	Leppert (1973a) Nolan (1977)
Research in general.	Morley (1976)		Grob (1967) Heilig et al. (1968) Sata (1974) Siepker et al. (1977)	U.S. Dept. of Health, Education, and Welfare (1971)	Levin (1973)